

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-2)

## CERTIFICATE OF DEATH

Reg. Dist. No. 141

## 1. PLACE OF DEATH:

County... Frederick  
 City or town... Brunswick  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 32 yrs.  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Maryland County... Frederick  
 City or town... Brunswick  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 403 No. Maple Ave.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

HARMON L. AHALT

## 3. (b) Social Security Number

4. Sex... M 5. Color or race... W 6. (a) Single, married, widowed, or divorced... Widowed  
 6. (b) Name of husband or wife... Anna M. Eyler  
 6. (c) If alive, give age... years  
 7. Birth date of deceased (mo., day, yr.) Dec. 7th. 1871  
 8. AGE: Years 73 Months 8 Days 4 If less than one day... hrs. min.

9. Birthplace... Maryland  
 (Town, county, and state)  
 10. Usual occupation... Retired  
 11. Industry or business

12. Name... Jhousa D. Ahalt  
 13. Birthplace... Maryland  
 14. Maiden name... Laura Shafer  
 15. Birthplace... Maryland

16. Informant... Mehrl E. Ahalt  
 Address... Brunswick, Maryland.

17. Burial Date thereof... 8-14-45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory... Lutheran Cemetary  
 Location... Middletown, Maryland

18. Funeral director... C. H. Feete and Bro.  
 Address... Brunswick, Maryland

19. Aug. 14 - 1945 Emma Martini  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... Aug 11 1945  
 21. I CERTIFY that death occurred on the date above stated that I attended deceased from July 15 - Aug 11 1945  
 and that I last saw him alive on Aug 7 1945  
 Immediate cause of death... Cerebral Hemorrhage  
 Due to... Hypertension  
 Due to... Hypertension  
 Other conditions...  
 (Include pregnancy within 3 months of death)

Major findings of operations... Date of op...  
 Autopsy results...  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide... Date of...  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of Injury Injured at work?

23. SIGNATURE... Date signed 8/14/45  
 Address... M. D. or other



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 144

## 1. PLACE OF DEATH:

County FrederickCity or town Thurmont  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 41 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Thurmont  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Mary A. Albaugh3. (b) Social Security Number  
none

## 4. Sex

F

## 5. Color or race

W

## 6.(a) Single, married, widowed, or divorced

Married8.(b) Name of husband or wife Maurice J. Albaugh7. Birth date of deceased (mo., day, yr.) July 2, 18756.(c) If alive, give age 85 years8. AGE: Years 70 Months 1 Days 21  
If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation Housework

11. Industry or business

12. Name Charles C. Currens13. Birthplace Maryland14. Maiden name Amanda Shaffer15. Birthplace Maryland16. Informant Mr. Maurice J. AlbaughAddress Thurmont, Maryland17. Burial Date thereof August 25, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory United Brethern CemeteryLocation Thurmont, Maryland.18. Funeral director C.O. Fuss & SonAddress Taneytown, Md.19. Aug 24 1945 Anna M. Jones  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 1945 at 1:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1945 to August 22 1945  
and that I last saw her alive on August 22 1945Immediate cause of death benignancy of the uterus DURATION 1 year

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE James K. Gray M.D. M. D. or otherAddress Thurmont, Md. Date signed 8/23/45

RECEIVED  
AUG 27 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:  
 County Frederick  
 City or town Frederick  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 25 years  
 Hospital, institution, or street address where death occurred:  
179 West All Saint Street  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Frederick  
 City or town Frederick  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 179 West All Saint Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war World War I

## 3. (a) FULL NAME

JAMES SABROSIA AMBUSH

## 3. (b) Social Security Number

4. Sex M 5. Color or race C 6.(a) Single, married, widowed, or divorced S  
 6.(b) Name of husband or wife  
 6.(c) If alive, give age ..... years  
 7. Birth date of deceased (mo., day, yr.) January 20, 1897  
 8. AGE: Years 48 Months 7 Days 1 If less than one day ..... hrs. .... min.

9. Birthplace Tuscarora-Frederick-Maryland  
 (Town, county, and state)

10. Usual occupation Laborer

## 11. Industry or business

FATHER 12. Name Joseph R. Ambush  
 13. Birthplace Frederick County Maryland  
 MOTHER 14. Maiden name Agnes Barton  
 15. Birthplace Frederick County Maryland

16. Informant Mrs. Agnes B. Ambush  
 Address 179 W. All Saint St., Fred'k, Md.

17. Burial Date thereof 8/24/45  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Fairview Cemetery  
Frederick, Maryland  
 Location M. R. Etchison and Son

18. Funeral director Frederick, Maryland  
 Address

19. 8/22 19 45 Elyabeth Heale  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 21st, 1945 at 4:45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 20, 1945 to August 21, 1945  
 end that I last saw him alive on August 21, 1945

Immediate cause of death Coronary Occlusion  
Chronic Myocarditis  
 DURATION 77

Due to  
 Due to

Other conditions Severe Gastro-Enteritis 10 days  
with Thrombotic Hemorrhoids  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Howard W. Oak M. D.  
 M. D. or other  
 Address Frederick, Maryland Date signed 8-22-45

RECEIVED  
AUG 24 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(131-2)

## CERTIFICATE OF DEATH

08009



Reg. Dist. No. 131

## 1. PLACE OF DEATH:

County FrederickCity or town Frederick-Rural  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency HospitalHow long in hospital or institution? 22 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Frederick  
(If outside city or town limits, write RURAL and give nearest town)Street No. 144 East South Street

(If rural, give LOCATION)

2. (a) If veteran, name war None

## 3. (a) FULL NAME

JAMES HENRY BARNES

## 3. (b) Social Security Number

None

## 4. Sex

M

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

WB. (b) Name of husband or wife Emma Steele

B. (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 31, 18718. AGE: Years 74 Months 4 Days 21 hrs. .... min.9. Birthplace Ellicott City-Howard-Maryland  
(Town, county, and state)10. Usual occupation None

11. Industry or business

12. Name Unknown13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant Mr. Ralph J. BeachtAddress 144 E. South St., Frederick, Md.17. Burial Union Chapel Cemetery  
(Burial, cremation, or removal. Which?) Date thereof 8/24/45  
(month) (day) (year)Cemetery or crematory Near Libertytown, MarylandLocation M. R. Etchison and Son18. Funeral director Frederick, MarylandAddress Frederick, Maryland19. Aug. 23 19 45 Elizabeth H. Heck  
(Date rec'd by registrar) F. M. H. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 22, 19 45, at 5:45A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 1 19 45 to Aug 22 19 45  
and that I last saw him alive on Aug 21 19 45

Immediate cause of death

DURATION

Cardiac DecompensationDue to Chronic Cardiac Muscular Degeneration

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. Lawrence Fahmy M. D.  
M. D. or otherAddress Frederick, Maryland Date signed 8-22-45



CERTIFICATE OF DEATH

RECEIVED  
AUG 27 1945  
BUREAU V.B.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

08910

★ Reg. Dist. No. 131

<b>1. PLACE OF DEATH:</b> County <u>Frederick</u> City or town <u>Frederick</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>8 Days</u> Hospital, institution, or street address where death occurred: <u>Frederick City Hospital</u> How long in hospital or institution? <u>8 Days</u>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Frederick</u> City or town <u>Tuscarora - Rural</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>Licksville</u> (If rural, give LOCATION) 2. (a) If veteran, name war <u>None</u>			
<b>3. (a) FULL NAME</b> <u>ALICE LILLIAN BELL</u>						<b>3. (b) Social Security Number</b> <u>None</u>	
<b>4. Sex</b> <u>F</u>		<b>5. Color or race</b> <u>W</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>S</u>			
<b>6. (b) Name of husband or wife</b> .....							
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>October 19, 1873</u>							
<b>8. AGE:</b> Years <u>71</u>		Months <u>10</u>		Days <u>10</u>		If less than one day .....hrs. ....min.	
<b>9. Birthplace</b> <u>Pittsburgh, Pa.</u> (Town, county, and state)							
<b>10. Usual occupation</b> <u>At Home</u>							
<b>11. Industry or business</b>							
FATHER	<b>12. Name</b> <u>Samuel H. Bell</u>						
	<b>13. Birthplace</b> <u>Paris, Pa.</u>						
MOTHER	<b>14. Maiden name</b> <u>Ann Frances Robinson</u>						
	<b>15. Birthplace</b> <u>Ireland</u>						
<b>16. Informant</b> <u>Miss Mary B. Bell</u> Address <u>Tuscarora, Maryland</u>							
<b>17. Burial</b> Date thereof <u>9/1/45</u> (Burial, cremation, or removal. Which?) (month) (day) (year) Cemetery or crematory <u>Mount Olivet Cemetery</u> Location <u>Frederick, Maryland</u> <u>M. R. Etchison and Son</u> <b>16. Funeral director</b> Address <u>Frederick, Maryland</u>							
<b>19.</b> <u>30-Aug</u> 19 <u>45</u> <u>Elizabeth Etchison</u> (Date rec'd by registrar) Registrar							
<b>MEDICAL CERTIFICATION</b>							
<b>20. DATE OF DEATH</b> <u>August 29th, 45</u> at <u>5:15P</u> M							
<b>21. I CERTIFY</b> that death occurred on the date above stated; that I attended deceased from <u>June 19, 43</u> to <u>Aug. 29, 45</u> and that I last saw him alive on <u>Aug. 29, 45</u> .							
<b>Immediate cause of death</b> <u>Cerebral Artery Disease with myelomeningitis</u>							
<b>DURATION</b> <u>?</u>							
<b>Due to</b> .....							
<b>Due to</b> .....							
<b>Other conditions</b> .....							
(Include pregnancy within 3 months of death)							
<b>Major findings of operations</b> .....							
Date of op. ....							
<b>Autopsy results</b> .....							
<b>PHYSICIAN:</b> Please underline the cause to which death should be charged statistically.							
<b>22. VIOLENCE:</b> If death was due to external causes, fill in the following:							
Accident, suicide, or homicide. Date of .....							
Where did injury occur? (City or town) (County) (State)							
Injured at home, farm, industry, public place (where?) .....							
Means of injury Injured at work?							
<b>23. SIGNATURE</b> <u>Howard W. Ark</u> M. D. Address <u>Frederick, Maryland</u> Date signed <u>8-30-45</u>							

WARTLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED  
SEP 1 1945  
BUREAU V.R.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

### 1. PLACE OF DEATH:

Country Frederick  
City or town Frederick  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 18 days  
Hospital, institution, or street address where death occurred Meigs Hospital  
How long in hospital or institution 18 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Frederick  
City or town Frederick  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. East Street  
(If rural, give LOCATION)  
2. (a) If veteran, name war.

### 3. (a) FULL NAME

Susan Stella Bennett

### 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

8. (b) Name of husband or wife Samuel Curtis Bennett

7. Birth date of deceased (mo., day, yr.) November 2, 1866 6. (c) If alive, give age 77 years

8. AGE: Years 79 Months 9 Days 13 If less than one day hrs. min.

9. Birthplace Frederick, Frederick Co., Maryland  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Heat Weller

12. Name Frederick County, Maryland

13. Birthplace Unknown

14. Maiden name Unknown

15. Birthplace Frederick, Md.

16. Informant Meigs Hosp. Frederick Md.

17. Date thereof Aug 17, 1945  
(month) (day) (year)

18. Cemetery or place of burial United Brethren

Location Thurmont, Md.

18. Funeral director M. S. Casper, Jr.

Address Thurmont, Md.

19. 17-Aug 1945

(Date rec'd by registrar) Elizabeth G. Hecks Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH August 15, 1945 at 1 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 15, 1945 and that I last saw him alive on August 14, 1945

Immediate cause of death Myocardial Infarction

Due to Cardio Vascular Aneurysm

Other conditions Fracture of hip

(Include pregnancy within 3 months of death)

Major findings of operations Fracture due to accidental fall, 5 months

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Accidental fall Injured at work?

23. SIGNATURE H. Lawrence Fahmy MD

Address Frederick Md

Date signed 8-15-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 18 1945

BUREAU

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

## CERTIFICATE OF DEATH

08012

Reg. Dist. No. 131

1. PLACE OF DEATH:  
County Frederick  
City or town Frederick  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred Emergency Hospital  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Frederick  
City or town Frederick  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 524 Richards St.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME Baby Boy Blackstone

3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced 3.

8. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) August 28, 1945 8. (c) If alive, give age years

8. AGE: Years 0 Months 0 Days 9 less than one day hrs. min.

9. Birthplace Frederick, Frederick Co., Maryland  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name James William Brown

13. Birthplace Frederick Co., Maryland

14. Maiden name Josephine Mae Blackstone

15. Birthplace Frederick Co., Maryland

18. Informant Dr. George L. L. L.

Address Emergency Hosp. Frederick, Md.

17. Burial Date thereof Aug 29-1945  
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Montrose Cem.

Location Frederick Co. Md.

18. Funeral director G. L. Trout Supt.

Address Frederick Co Maryland

19. 29-Aug 19 45 Elizabeth G. Heck  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH August 28, 1945 at 11:15 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 28, 1945 to 1945

and that I last saw alive on 1945

Immediate cause of death Pre maturity DURATION 1 day

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. E. Harp MD M. D. or other

Address Frederick, Md. Date signed 8-29-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

RECEIVED

RECEIVED

AUG 30 1945

BUREAU V.R.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH: Frederick  
 County..... Frederick  
 City or town..... Frederick  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... Lifetime  
 Hospital, institution, or street address where death occurred:  
 235 East Church Street  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... Maryland County..... Frederick  
 City or town..... Frederick  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 235 East Church Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... None

## 3. (a) FULL NAME

GUY BLACKSTON

## 3. (b) Social Security Number

214-10-2672

4. Sex..... Male 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Married  
 6.(b) Name of husband or wife..... Bertha Edmonds  
 6.(c) If alive, give age..... 66 years  
 7. Birth date of deceased (mo., day, yr.)..... August 31-1875  
 8. AGE: Years..... 69 Months..... 11 Days..... 12 If less than one day..... hrs. .... min.

9. Birthplace..... Frederick County Maryland  
 (Town, county, and state)  
 10. Usual occupation..... Salesman  
 11. Industry or business..... Dry Goods Business  
 12. Name..... B.H. Blackston  
 13. Birthplace..... Frederick County Maryland  
 14. Maiden name..... Josephine Warthan  
 15. Birthplace..... Frederick County Md.

16. Informant..... Mrs. Bertha Blackston  
 Address..... 235 E. Church St.- Frederick, Md.

17. Burial (Burial, cremation, or removal, which?)..... Date thereof..... Aug. 14-45 (month) (day) (year)  
 Cemetery or crematory..... Mount Olivet Cemetery  
 Location..... Frederick, Md.  
 18. Funeral director..... C.E. Cline and Son  
 Address..... Frederick, Md.

19. 14 Aug 1945- Elizabeth G. Heck  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... August 12th. 1945 at 8:15a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 10 1945 to Aug. 12 1945 and that I last saw him alive on Aug. 12 1945

Immediate cause of death..... Acute Coronary Thrombosis DURATION 1 1/2 hrs.  
 Due to.....  
 Due to.....  
 Other conditions..... Angina Pectoris, Diabetes mellitus DURATION 1 yr.  
 (Include pregnancy within 8 months of death)

Major findings of operations..... none Date of op.....

Autopsy results..... none  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?

23. SIGNATURE..... A. Austin Jones M.D.  
 Address..... Frederick, Md. M.D. or other 8/14/45  
 Date signed.....



UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

IN THE CITY OF NEW YORK

STATE OF NEW YORK

DEPARTMENT OF HEALTH

RECEIVED

AUG 16 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH: Frederick  
 County Frederick  
 City or town Frederick  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 1/2 years  
 Hospital, institution, or street address where death occurred: Frederick City Hospital  
 How long in hospital or institution? 3 1/2 years

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For ~~born~~ infants give residence of mother)  
 State Maryland County Frederick  
 City or town Middletown RFO  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. None  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

3. (a) FULL NAME Sallie Shaper Bowler

3. (b) Social Security Number None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife Chas. H. Bowler

7. Birth date of deceased (mo., day, yr.) Jan. 10, 1863  
 8. AGE: Years 82 Months 7 Days 5 If less than one day hrs. min.

9. Birthplace Middletown, Frederick County, Md.  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Thomas Shaper

12. Name Thomas Shaper

13. Birthplace Middletown, Md.

14. Maiden name Lucretia Rudy

15. Birthplace Middletown, Md.

16. Informant Lucretia Bowler  
 Address Washington, D.C.

17. Burial Burial Date thereof Aug. 18, 1945  
 (Burial, cremation, or removal, which) (month) (day) (year)  
 Cemetery or crematory Reformed  
 Location Middletown, Md.

18. Funeral director Leathner Co.  
 Address Middletown, Md.

19. Aug 17 19 45 Elizabeth G. Heck  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15 19 45 at 4:50 P. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 6 19 45 to Aug 15 19 45  
 and that I last saw her alive on Aug 15 19 45

Immediate cause of death Coronary Occlusion  
 Due to Coronary Sclerosis  
 Due to Myocarditis  
 Other conditions Myocarditis  
Senility  
 (Include pregnancy within 3 months of death)

DURATION  
15 mi  
10 y 10  
15 y 10

Major findings of operations None  
 Date of op. None  
 Autopsy results None  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide None Date of None  
 Where did injury occur? None (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) None  
 Means of injury None Injured at work? None

23. SIGNATURE C. L. Brice  
Jefferson M. D. or other  
 Address None Date signed 8/16/45

RECEIVED

AUG 21 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH: Frederick  
 County Frederick  
~~City or town~~ Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution? Montrose

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State MD. County Frederick  
~~City or town~~ near Frederick Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

3. (a) FULL NAME Samuel Briscoe

3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single

8. (b) Name of husband or wife \_\_\_\_\_ 6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years 75 Months - Days - It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Buffettville Md.  
 (town, county, and state)

10. Usual occupation Farm hand

11. Industry or business \_\_\_\_\_

12. Name John Briscoe

13. Birthplace Frederick Co Md.

14. Maiden name Sarah Parker

15. Birthplace Frederick Co Md.

16. Informant Records at Montrose

Address Frederick Md.

17. Burial Date thereof Aug 8 - 45  
 (Burial, cremation, or removal - Which?) (month) (day) (year)

Cemetery or crematory Montrose

Location near Frederick Md.

18. Funeral director E. E. Glavin & Son

Address Frederick Md.

19. 6-Aug 1945 Elizabeth G. Heck  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 5 1945 at 7:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 4 1945 to Aug 5 1945

and that I last saw him alive on Aug 3 1945

Immediate cause of death \_\_\_\_\_

Carcinoma of Liver DURATION 3 mo.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Ante-mortem results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE James Hays Md M. D. or other \_\_\_\_\_

Address Middleton Date signed 8-5-45

RECEIVED  
AUG 8 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 139

## 1. PLACE OF DEATH:

County Frederick  
 City or town State Sanatorium, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Since 7/9/45  
 Hospital, institution, or street address where death occurred:  
Maryland Tuberculosis Sanatorium  
 How long in hospital or institution? Since 7/9/45

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Carroll  
 City or town Westminster  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 154 W. Main St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war ☒

## 3.(a) FULL NAME

Edith E. Brown

## 3.(b) Social Security Number

None

## 4. Sex

Female

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband ~~Wife~~

William Brown

## 7. Birth date of deceased (mo., day, yr.)

August 24, 1899

## 6.(c) If alive, give age.....years

## 8. AGE:

Years

Months

Days

If less than one day

46

0

2

hrs.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual occupation Housewife

## 11. Industry or business

## FATHER

## 12. Name

Albert S. Share

## 13. Birthplace

Baltimore, Md.

## MOTHER

## 14. Maiden name

Sue Hubbard

## 15. Birthplace

Baltimore, Md.

16. Informant Deceased

## Address

## 17.

(Burial, cremation, or removal. Which?)

## Date thereof

(month) (day) (year)

## Cemetery or crematory

## Location

## 18. Funeral director

## Address

## 19.

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 19 45, at 4:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 9 19 45, to August 26 19 45and that I last saw her alive on August 26 19 45

## Immediate cause of death

Pulmonary Tuberculosis

## DURATION

19 Mos.

## Due to

Tuberculous Enteritis1 Mo.

## Due to

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

## 23. SIGNATURE

John H. Hunsfeldt  
M. D.Address State Sanatorium, Md. Date signed 8/27/45

RECEIVED  
AUG 28 1945  
STREET V.B.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:  
 County..... Frederick  
 City or town..... Frederick  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 50 years  
 Hospital, institution, or street address where death occurred:  
213 East Patrick St.  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... Maryland County..... Frederick  
 City or town..... Frederick  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 213 East Patrick Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... None

## 3. (a) FULL NAME

AMON BURGEE

## 3. (b) Social Security Number

4. Sex..... Male 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Married  
 6. (b) Name of husband or wife..... Mary Elizabeth Burgee  
 6. (c) If alive, give age..... 75 years  
 7. Birth date of deceased (mo., day, yr.)..... April 16, 1865  
 8. AGE: Years..... 80 Months..... 3 Days..... 21 If less than one day..... hrs. .... min.

9. Birthplace..... Hyattstown, Maryland  
 (Town, county, and state)  
 10. Usual occupation..... Retired Educator  
 11. Industry or business.....

12. Name..... Miel Burgee  
 13. Birthplace..... Frederick County, Maryland  
 14. Maiden name..... Clara Elizabeth Dawson  
 15. Birthplace..... Frederick County, Maryland

16. Informant..... Mrs. Amon Burgee  
 Address..... Frederick, Maryland

17. Burial..... Aug. 9, 1945  
 (Burial, cremation, or removal. Which?) Date thereof..... (month) (day) (year)  
 Cemetery or crematory..... Mt. Olivet Cemetery  
 Location..... Frederick, Maryland

18. Funeral director..... C. E. Cline & Son  
 Address..... Frederick, Maryland

19. 9-Aug-45 Eligbeth G. Hack  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... August 6 19 45, at 3.30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1 19 45 to Aug. 6 19 45  
 and that I last saw him alive on Aug. 6 19 45  
 Immediate cause of death.....

DURATION..... 6 mo  
Carcinoma of prostate  
 Due to.....  
 Due to.....  
 Other conditions..... Secondary Gynaecoma  
 (Include pregnancy within 3 months of death)

Major findings of operations.....  
 Date of op.....  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?

23. SIGNATURE..... A. A. Pearce M.D.  
 Address..... Frederick, Md Date signed 8/9/45

CERTIFICATE OF DEATH

RECEIVED  
AUG 10 1945  
BUREAU V.S.

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

## CERTIFICATE OF DEATH

★ Reg. Dist. No. 136

## 1. PLACE OF DEATH:

County **Frederick**  
 City or town **Frederick-Rural R. F. D. #2**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? **40 years**  
 Hospital, institution, or street address where death occurred:  
**Urbana**  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State **Maryland** County **Frederick**  
 City or town **Frederick-Rural R. F. D. #2**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. **Urbana**  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war **None**

## 3. (a) FULL NAME

**WILLIAM CADLE**

## 3. (b) Social Security Number

**None**

4. Sex **M** 5. Color or race **W** 6. (a) Single, married, widowed, or divorced **M**  
 6. (b) Name of husband or wife **Vaudelia Tschiffely**  
 6. (c) If alive, give age **61** years  
 7. Birth date of deceased (mo., day, yr.) **February 7, 1859**  
 8. AGE: Years **86** Months **6** Days **6** If less than one day  
 hrs. min.

9. Birthplace **Anne Arundle County Maryland**  
 (Town, county, and state)  
 10. Usual occupation **Retired Farmer**  
 11. Industry or business

FATHER 12. Name **James Cadle**  
 13. Birthplace **Maryland**  
 MOTHER 14. Maiden name **Susanna Woodward**  
 15. Birthplace **Maryland**

16. Informant **Dr. William R. Cadle**  
 Address **Emmitsburg, Maryland**

17. **Burial** Date thereof **8/15/45**  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory **Mount Olivet Cemetery**  
**Frederick, Maryland**  
 Location

16. Funeral director **M. R. Etchison and Son**  
**Frederick, Maryland**  
 Address

19. **Aug 15** 19 **46**  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH **August 13th, 1945** at **2:15P. M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **Aug 13** **1945** to **Aug 13** **1945**  
 and that I last saw him alive on **Aug 13** **1945**

Immediate cause of death **Coronary Thrombosis** DURATION **2h**

Due to  
 Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE **M. D.**

**Frederick, Maryland** M. D. or other  
 Address Date signed **8-14-45**

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
AUG 20 1945  
BUREAU V.B.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 139

### 1. PLACE OF DEATH:

County Frederick  
City or town State Sanatorium, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Since 6/18/45  
Hospital, institution, or street address where death occurred:  
Maryland Tuberculosis Sanatorium  
How long in hospital or institution? Since 6/18/45

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County \_\_\_\_\_  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1125 Abbott Street  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Walter Coleman

### 3. (b) Social Security Number

21707-6179

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Separated

6.(b) Name of ~~husband~~ wife Audrey Coleman

7. Birth date of deceased (mo., day, yr.) August 21, 1914 6.(c) If alive, give age 23 years

8. AGE: Years 30 Months 11 Days 17 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace West Virginia  
(Town, county, and state)

10. Usual occupation Painter

11. Industry or business \_\_\_\_\_

FATHER 12. Name Benjamin Coleman  
13. Birthplace W. Va.

MOTHER 14. Maiden name Viola Cummings  
15. Birthplace W. Va.

16. Informant Deceased

Address \_\_\_\_\_

17. Burial Date thereof Aug. 10, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Card will be sent in

Location when received from the

18. Funeral director Undertaker C. F. Hoffman

Address 1639 N. Broadway

19. 8/7/45 19. \_\_\_\_\_

(Date rec'd by registrar) Registrar \_\_\_\_\_

### MEDICAL CERTIFICATION

20. DATE OF DEATH August 7 19 45 at 3 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 18 19 45 to August 7 19 45 and that I last saw him alive on August 7 19 45

Immediate cause of death Pulmonary Tuberculosis DURATION 8 Mos.

~~XXXXX~~ Laryngeal Tuberculosis 4 Mos.

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J. B. Lyn M. D. State Sanatorium, Md.  
Address \_\_\_\_\_ Date signed 8/7/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 9 1945

BUREAU V.B.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6)

## CERTIFICATE OF DEATH

08920

Reg. Dist. No. 131

## 1. PLACE OF DEATH:

County Frederick  
 City or town Frederick  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 24 hours  
 Hospital, institution, or street address where death occurred:  
Frederick City Hospital  
 How long in hospital or institution? 240 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Frederick  
 City or town Thurmont  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Cover, William Henry

## 3. (b) Social Security Number

212-14-7027

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Mettie Hesson Cover7. Birth date of deceased (mo., day, yr.) Nov. 12, 1870

8. AGE: Years 74 Months 9 Days 9 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation Clerk in Store

## 11. Industry or business

12. Name David Cover13. Birthplace Maryland14. Maiden name Anna (McKell) Cover15. Birthplace Maryland16. Informant Miss Cassandra HessonAddress Thurmont, Maryland17. Burial Date thereof 8-23-45  
(Burial, cremation, or removal) (month) (day) (year)Cemetery or crematorium United Brethren CemeteryLocation Thurmont, Maryland18. Funeral director Willhild & CreegerAddress Thurmont, Maryland19. Aug-23- 1945 Elizabeth G. Ideck  
(Date rec'd by registrar) E.M.H. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 21 1945, at 12:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 20 1945, to August 21 1945  
 and that I last saw him alive on August 21 1945

Immediate cause of death Cerebral thrombosisDue to Arterio sclerosis

Due to \_\_\_\_\_

Other conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Anteopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE J. R. Schoolman M.D.Address Frederick Md Date signed 8/21/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



ESTIMATES OF DEATH

U.S. DEPARTMENT OF HEALTH

RECEIVED

AUG 27 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 482

## CERTIFICATE OF DEATH



Reg. Diat. No. 18021/41

## 1. PLACE OF DEATH:

County... *Frederick*City or town... *Knorrville*  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *Life*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... *Maryland* County... *Frederick*City or town... *Knorrville*  
(If outside city or town limits, write RURAL and give nearest town)Street No. ....  
(If rural, give LOCATION)

2(a) If veteran, name war .....

## 3. (a) FULL NAME

*Opie G. Crampton*

## 3. (b) Social Security Number

4. Sex *Female* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Widowed*6. (b) Name of husband or wife *Clarence G. Crampton*7. Birth date of deceased (mo., day, yr.) *Jan 5, 1865*8. AGE: Years *80* Months *7* Days *8* If less than one day ..... hrs. .... min.9. Birthplace *Knorrville, Frederick, Md*  
(Town, county, and state)10. Usual occupation *Retired*11. Industry or business *Domestic*12. Name *Milton G. Crampton*13. Birthplace *Md.*14. Maiden name *Emma Harper*15. Birthplace *Md.*16. Informant *Mrs. Thos. C. Biddle*Address *Knorrville, Md*17. *Burial* Date thereof *Aug. 15, 1945*  
(Burial, cremation, or removal) (month) (day) (year)Cemetery or crematory *St. Mark's Episcopal*Location *Petersville, Md.*18. Funeral director *J. Thos. Biddle & Son*Address *Myersville, Md.*19. *Aug. 15, 1945* *Emma Mantz*  
(Date rec'd by registrar) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *August 13, 1945*, at *4:20 AM*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Aug 1, 1945* to *Aug 13, 1945*and that I last saw her alive on *Aug 12, 1945*Immediate cause of death *Myocardial infarct*

## DURATION

*2 Days*Due to *Malnutrition**1 mo*Due to *Cerebral Palsy**(?)*

Primary carcinoma of uterus, cancer

Other conditions *Senility, advanced arteriosclerosis.*

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. .... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *G. J. Brice* M. D. or otherAddress *Jefferson* Date signed *8/14/45*

RECEIVED  
AUG 18 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 141

## 1. PLACE OF DEATH:

County FredrickCity or town Brunswick  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 53 yrs

Hospital, institution, or street address where death occurred:

112 N. 5th Ave

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FredrickCity or town Brunswick  
(If outside city or town limits, write RURAL and give nearest town)Street No. 112 N. 5th Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

John Peter Detrick

## 3.(b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Mary C. Shepper

7. Birth date of deceased (mo., day, yr.)

May 13 - 1865

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

80316

hrs.

min.

9. Birthplace

Germany  
(Town, county, and state)

10. Usual occupation

Br & RR Laborer

11. Industry or business

Retired

12. Name

John J. Detrick

13. Birthplace

Germany

14. Maiden name

Elizabeth

15. Birthplace

Germany

16. Informant

Max Lillian M. Detrick

Address

Brunswick Md

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

Sept 1 1945  
(month) (day) (year)

Cemetery or crematory

Not listed

Location

Fredrick Md

18. Funeral director

L. H. Fultz & Son

Address

Brunswick Md

19. (Date rec'd by registrar)

Sept 1 - 1945Emma MartinRegist

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 30 1945 at 4 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 28 1945 to Aug 30 1945and that I last saw him alive on Aug 28 1945

Immediate cause of death

Decompensated heart

DURATION

2

Due to

arterio-sclerotic degeneration

Due to

arterio-sclerotic degeneration

Other conditions

arterio-sclerotic degeneration

Other conditions

arterio-sclerotic degeneration

Other conditions

arterio-sclerotic degeneration

Other conditions

arterio-sclerotic degeneration

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Other conditions

arterio-sclerotic degeneration

Other conditions

arterio-sclerotic degeneration

Other conditions

RECEIVED  
SEP 5 1945  
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

## CERTIFICATE OF DEATH

08023

Reg. Dist. No. 131

## 1. PLACE OF DEATH:

County FrederickCity or town Rural  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Emergency HospitalHow long in hospital or institution? 10 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town #10 Hillside Apts.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 10 Hillside Apts.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Joyce Joan Ford

## 3. (b) Social Security Number

None

4. Sex Female5. Color or race white6. (a) Single, married, widowed, or divorced S

6. (b) Name of husband or wife

B. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 19, 19458. AGE: Years 0 Months 0 Days 10 If less than one day  
hrs. min.9. Birthplace Frederick-Frederick-Maryland  
(Town, county, and state)10. Usual occupation Infant

## 11. Industry or business

12. Name Raymond H. Ford  
13. Birthplace Berryville, Virginia14. Maiden name Kathleen Sease15. Birthplace Martinsburg, West Virginia16. Informant Raymond H. Ford  
Address #10 Hillside Apts, Frederick, Md.17. Burial Mount Olivet Cemetery  
(Burial, cremation, or removal, which?) Date thereof 8/29/45  
(month) (day) (year)Cemetery or crematory Frederick, MarylandLocation M. R. Etchison and Son18. Funeral director Frederick, MarylandAddress Frederick, Maryland19. Date rec'd by registrar 29-Aug-45  
(Date rec'd by registrar) Registrar Elizabeth G. Heck

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 29, 1945 at 3:40 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 19, 1945 to Aug. 29, 1945and that I last saw him alive on Aug 28 1945Immediate cause of death Edema of lungs

## DURATION

premature 8 months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. O. Thomas M. D.

M. D. or other

Address Frederick, Maryland Date signed 8-29-45

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U.S. DEPARTMENT OF HEALTH

OFFICE OF THE ASSISTANT SECRETARY

RECEIVED

AUG 30 1945

BUREAU U.S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

## CERTIFICATE OF DEATH

08024

Reg. Dist. No. 132

### 1. PLACE OF DEATH:

County Fredrick  
 City or town Middletown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MD County Fredrick  
 City or town Middletown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

### 3. (a) FULL NAME

Baby Boy Baver

### 3. (b) Social Security Number

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced Single

8. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) August 25, 1945 6. (c) If alive, give age 0 years

8. AGE: Years 0 Months 0 Days 0 If less than one day 13 1/4 hrs. 0 min.

9. Birthplace Middletown, Md.  
 (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Everette W. Baver

13. Birthplace Middletown, Md.

14. Maiden name Anabell Holder

15. Birthplace Weavertown, Md.

16. Informant Anabell Baver

Address Middletown, Md.

17. Burial Date thereof 8-25-45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Lutheran Cemetery

Location Middletown, Md.

18. Funeral director Bladhill Co.

Address Middletown, Md.

19. Aug 25 19 45 Marion Bladhill  
 (Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25 19 45 at 1:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 25 19 45 to Aug 25 19 45 and that I last saw him alive on Aug 25 19 45

Immediate cause of death

Prematurity

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) (County) (State)

Means of injury Injured at work?

23. SIGNATURE J E Harp MD M. D. or other

Address Middletown Date signed Aug 25-45

RECEIVED BY MAIL

RECEIVED

SEP 4 1945

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

08025

137

1. PLACE OF DEATH:  
 County... Frederick  
 City or town... Mount Airy - Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 years  
 Hospital, institution, or street address where death occurred:  
Near Linganore  
 How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State... Maryland County... Frederick  
 City or town... Mount Airy - Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Near Linganore  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war... None

3. (a) FULL NAME  
KENRY WALTER HAHN

3. (b) Social Security Number  
None

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced M

6. (b) Name of husband or wife... Elsie Lease

7. Birth date of deceased (mo., day, yr.) July 30, 1875 8. (c) If alive, give age 58 years

8. AGE: Years 70 Months 0 Days 8 If less than one day  
 ....hrs. ....min.

9. Birthplace... Walkersville-Frederick-Maryland  
 (Town, county, and state)

10. Usual occupation... Farmer

11. Industry or business

12. Name... John M. Hahn

13. Birthplace... Unknown

14. Maiden name... Margaret E. Werking

15. Birthplace... Unknown

16. Informant... Mrs. Elsie L. Hahn

Address... Mount Airy, Md. R. F. D.

17. Burial Date thereof... 8/11/45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Fairmount Cemetery

Location... Libertytown, Maryland

18. Funeral director... M. R. Etchison and Son

Address... Frederick, Maryland

19. Aug 10 19 45 W. L. Curfman  
 (Date used by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... August 8, 19 45 at 10:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 4 19 37 to Aug 8 19 45 and that I last saw him alive on Aug 7 19 45

Immediate cause of death... Advanced

Due to... Advanced

Other conditions... Advanced

Due to... Advanced

Other conditions... Advanced

Due to... Advanced

Other conditions... Advanced

Due to... Advanced

Other conditions... Advanced

Due to... Advanced

Other conditions... Advanced

Due to... Advanced

Other conditions... Advanced

Due to... Advanced

Other conditions... Advanced

Due to... Advanced

Other conditions... Advanced

Due to... Advanced

Other conditions... Advanced

Due to... Advanced

Other conditions... Advanced

CERTIFICATE OF DEATH

REC-111  
AUG 13 1945  
BUREAU 78

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *MD*

## CERTIFICATE OF DEATH

Reg. Dist. No. *13*

### 1. PLACE OF DEATH:

County *Frederick*  
City or town *Rural*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred *Emergency Hospital*  
How long in hospital or institution? *3 days*

### 3. (a) FULL NAME

*David Lamar Haines*

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new born infants give residence of mother)

State *Maryland* County *Frederick*  
City or town *Frederick*  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. *811 Miller Avenue*  
(If rural, give LOCATION)

2. (a) If veteran, name war

### 3. (b) Social Security Number

#### 4. Sex

*Male*

#### 5. Color or race

*White*

#### 6. (a) Single, married, widowed, or divorced

#### 6. (b) Name of husband or wife

#### 7. Birth date of deceased (mo., day, yr.)

*August 21, 1945*

6. (c) If alive, give age years

#### 8. AGE:

Years

Months

Days

If less than one day

#### 9. Birthplace

*Frederick Fred Co, Maryland*  
(Town, county, and state)

#### 10. Usual occupation

#### 11. Industry or business

MOTHER  
FATHER

12. Name  
13. Birthplace  
14. Maiden name  
15. Birthplace

*James Elworth Haines*  
*Mt. Airy, Maryland*  
*Bertha Marie Bender*  
*Frederick Maryland*

#### 16. Informant

*Emergency Hosp. Frederick, Md.*

#### 17. Burial

*Burial* Date thereof *8/29/45*  
(Burial, cremation, or removal. Which) (month) (day) (year)

#### Cemetery or crematory

*Mt. Olivet Cemetery*

#### Location

*Frederick, Maryland*

#### 18. Funeral director

*M. R. Elchman*

#### Address

*Frederick, Maryland*

#### 19. Date rec'd by registrar

*29-Aug-45* Registrar *Elizabeth A. Hecks*

### MEDICAL CERTIFICATION

20. DATE OF DEATH *August 28, 1945* at *9:40 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Aug. 21, 1945* to *Aug. 28, 1945* and that I last saw him alive on *Aug. 28, 1945*

#### Immediate cause of death

*Atelectasis*

#### DURATION

*3 days*

#### Due to

#### Due to

#### Other conditions

(Include pregnancy within 8 months of death)

#### Major findings of operations

#### Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

#### 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *J. E. Hays MD*

Address *Middletown*

Date signed *8-29-45*

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

AUG 30 1945

BUREAU



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 139

08027

## 1. PLACE OF DEATH:

County..... **Frederick**  
 City or town..... **State Sanatorium, Maryland**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... **Since 7/29/43**  
 Hospital, institution, or street address where death occurred:  
**Maryland Tuberculosis Sanatorium**  
 How long in hospital or institution?..... **Since 7/29/43**

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... **Maryland** County..... **Carroll**  
 City or town..... **Union Bridge**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... ✓

## 3. (a) FULL NAME

**Edward Harrison Haines**

## 3. (b) Social Security Number

**None**

## 4. Sex

**Male**

## 5. Color or race

**White**

## 6. (a) Single, married, widowed, or divorced

**Married**6. (b) Name of ~~husband~~ wife**Mamie Haines**

## 7. Birth date of deceased (mo., day, yr.)

**March 1, 1889**

## 6. (c) If alive, give age..... years

## 8. AGE:

Years

Months

Days

If less than one day

**56****5****9**

..... hrs. .... min.

## 9. Birthplace

**Union Bridge, Md.**

(Town, county, and state)

## 10. Usual occupation

**Machinist**

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

**Frank Haines**

## 13. Birthplace

**Carroll County, Maryland**

## 14. Maiden name

**Fannie Fogle**

## 15. Birthplace

**Frederick County, Md.**

## 16. Informant

**Deceased**

## Address

## 17.

**Burial**

(Burial, cremation, or removal. Which?)

Date thereof.....

**8/12/45**

(month) (day) (year)

## Cemetery or place of burial

**Mt. View**

## Location

**Union Bridge, Md.**

## 18. Funeral director

**D. D. Hartzler & Sons**

## Address

**Union Bridge, Md.**

## 19.

**8/11**

19

**45**

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH..... **August 10** 19 **45**, at **7:15A** M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
**July 29** 19 **43** to **August 10** 19 **45**  
 and that I last saw him alive on **August 10** 19 **45**

## Immediate cause of death

**Pulmonary Tuberculosis**

## DURATION

**2 1/2 Yrs.**~~Next~~**Pulmonary Hemorrhage****Few**

## Due to

**minutes**

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

..... Date of op. ....

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work?

## 23. SIGNATURE

**J. B. Lynn**M. D. ~~XXXX~~Address..... **State Sanatorium, Md.** Date signed..... **8/10/45**



RECEIVED  
AUG 13 1945  
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

## 1. PLACE OF DEATH:

County... Frederick

City or town... Frederick  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:  
106 E. 2nd. St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Frederick

City or town... Frederick  
(If outside city or town limits, write RURAL and give nearest town)Street No... 106 E. 2nd. St.  
(If rural, give LOCATION)

2.(a) If veteran, name war... None

## 3. (a) FULL NAME

ANN ELIZABETH HALLER

## 3. (b) Social Security Number

None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) December 18-1867

8. AGE:	Years	Months	Days	It less than one day
	77	8	1	.....hrs. ....min.

9. Birthplace... Frederick, Frederick Co. Md.  
(Town, county, and state)

10. Usual occupation... Housekeeper

## 11. Industry or business

FATHER 12. Name... Thomas Haller

13. Birthplace... Frederick, Md.

MOTHER 14. Maiden name... Caroline R. Fessler

15. Birthplace... Frederick, Md.

16. Informant... J. Fessler Haller

Address... Niagara Falls, N.Y.

17. Burial Date thereof... Aug. 21-1945  
(Burial, cremation, or removal of remains)

Cemetery or crematory... Mount Olivet Cemetery

Location... Frederick, Md.

18. Funeral director... C.E.Cline and Son

Address... Frederick, Md.

19. 20 Aug 1945 Elizabeth G. Heck  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... August 19th. 1945 at 11 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 26th. 1945 to August 19 1945

and that I last saw her alive on August 18th. 1945

Immediate cause of death	DURATION
Carcinoma, Liver, and General Metastasis, extending over a period of years.	

Due to...  
Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op. ....

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... C.H. Conley, M.D. M. D. HALL

Address... Frederick, Maryland Date signed 8/20/45

CERTIFICATE OF DEATH

RECEIVED  
AUG 21 1945  
BUREAU V.S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

08029

★ Reg. Dist. No. 131

### 1. PLACE OF DEATH:

County Frederick  
City or town Frederick  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
Emergency Hospital  
How long in hospital or institution 7 days

### 3. (a) FULL NAME

Ara Harris

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Frederick  
City or town New Market  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

### 3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife Samuel Harris

7. Birth date of deceased (mo., day, yr.) Aug. 27, 1871 8. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 74 Months 0 Days 2 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home Shipley

12. Name Home Shipley

13. Birthplace MD

14. Maiden name Octavia

15. Birthplace MD

16. Informant Mrs. Cecilia Engle

Address New Market MD

17. Burial Date thereof Aug 31 - 45  
(Burial, cremation or removal) (month) (day) (year)

Cemetery or crematory Pleasant Hill

Location in Monrovia MD

18. Funeral director W. E. Falconer

Address New Market MD

19. 30 - Aug 19 45 Elizabeth H. Hark  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH August 29, 1945 at 10:55 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 27, 1945 to Aug 29, 1945 and that I last saw him alive on August 29, 1945

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Carcinoma uterus 1 1/2 yrs

Due to with metastases

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J. E. Harp MD M. D. or other \_\_\_\_\_

Address New Market Date signed 8-29-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

SEP 1 1945

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

## CERTIFICATE OF DEATH

08030

Reg. Dist. No. 131

## 1. PLACE OF DEATH:

County Frederick  
 City or town Frederick, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 1/2 hrs.  
 Hospital, institution, or street address where death occurred:  
Frederick City Hospital  
 How long in hospital or institution? New Born

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Frederick  
 City or town Frederick  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 212 College Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

Dorothy Harris

## 3. (b) Social Security Number

None

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced S  
 B.(b) Name of husband or wife xxxxxx  
 7. Birth date of deceased (mo., day, yr.) August 7th, 1945  
 8. AGE: Years Months Days If less than one day  
0 0 0 2 1/2 hrs. min.

9. Birthplace Frederick-Frederick-Maryland  
 (Town, county, and state)  
 10. Usual occupation Infant  
 11. Industry or business

12. Name Robert Leroy Harris  
 13. Birthplace Topeka, Kansas  
 14. Maiden name Dorothy Rozewski  
 15. Birthplace Detroit, Michigan

16. Informant Mrs. Dorothy Harris  
 Address 202 College Ave., Frederick, Md.

17. Burial Burial Date thereof 8/8/45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory St. Johns Cemetery  
 Location Frederick, Maryland

18. Funeral director M. R. Etchison and Son  
 Address Frederick, Maryland

19. 8 Aug 1945 Elizabeth E. Hedges  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 7 1945 at 2:30 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 7 1945 to August 7 1945  
 and that I last saw h.e. alive on August 7, 1945 1945

Immediate cause of death Prematurity (6 mos)  
 DURATION  
 Due to  
 Due to  
 Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.  
 Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE L. R. Schoolman M.D.  
 Address Frederick Md Date signed 8/7/45

RECEIVED  
AUG 9 1945  
BUREAU V.S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

08031

Reg. Dist. No. 144

## 1. PLACE OF DEATH:

County FrederickCity or town Rocky Ridge-Rural R. F. D. #1  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 Months

Hospital, institution, or street address where death occurred:

Near Creagerstown

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Rocky Ridge-Rural R. F. D. #1  
(If outside city or town limits, write RURAL and give nearest town)Street No. Near Creagerstown  
(If rural, give LOCATION)

2. (a) If veteran, name war

None

## 3. (a) FULL NAME

LAURA BELL HARRIS

## 3. (b) Social Security Number

None

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

W

6. (b) Name of husband or wife

Martin E. Harris

7. Birth date of

deceased (mo., day, yr.)

November 2, 1870

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

7496hrs.min.

8. Birthplace

Frederick County Maryland

(Town, county, and state)

10. Usual occupation

Practical Nurse

11. Industry or business

FATHER  
MOTHER

12. Name

Jacob Main

13. Birthplace

Frederick County Maryland

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Mrs. Harvey M. Lare

Address

Rocky Ridge, Md. R. F. D. #1

17.

Burial

Date thereof

8/10/45

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Union Chapel Cemetery

Location

Near Libertytown, Maryland

18. Funeral director

M. R. Etchison and Son

Address

Frederick, Maryland

19.

Aug 919 45Anna M. Jones

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 8 19 45 at 8 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

June 5 19 45 to Aug 8 19 45and that I last saw her alive on August 11 19 45

Immediate cause of death

Cerebral Hemorrhage

DURATION

Instant

Due to

Chronic Endocarditis2 yrs

Due to

Chronic Arterial Sclerosis5 yrs

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Morris A. Brief M.D.

M. D. or other

Address

Thurmont - Md

Date signed

8/8/45

CERTIFICATE OF DEATH

RECEIVED

AUG 11, 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08032

## CERTIFICATE OF DEATH

Reg. Diat. No. 139

## 1. PLACE OF DEATH:

County... Frederick  
 City or town... State Sanatorium, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Since 7/2/45  
 Hospital, institution, or street address where death occurred:  
Maryland Tuberculosis Sanatorium  
 How long in hospital or institution? Since 7/2/45

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County...  
 City or town... Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... 1813 Linden Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war...

## 3. (a) FULL NAME

Denver D. Hewett

## 3. (b) Social Security Number

232-07-7760

## 4. Sex

Male

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Married6.(b) Name of ~~husband~~ wife Agnes Hewett6.(c) If alive, give age 27 years

## 7. Birth date of

deceased (mo., day, yr.) Sept. 17, 1914

## 8. AGE:

Years

Months

Days

If less than one day

301021

...hrs. ...min.

## 9. Birthplace

Berkeley Springs, W.Va.  
(Town, county, and state)

## 10. Usual occupation

Machine Operator

## 11. Industry or business

## FATHER

## 12. Name

Isaac O. Hewett

## 13. Birthplace

Fulton Co., Pa.

## MOTHER

## 14. Maiden name

Rose B. Pittman

## 15. Birthplace

Fulton Co., Pa.

## 16. Informant

Deceased

## Address

## 17.

Burial  
(Burial, cremation, or removal. Which?)

## Date thereof

7/28/45  
(month) (day) (year)

## Cemetery or crematory

Greenwood

## Location

Berkeley Springs, W.Va.

## 18. Funeral director

Krass

## Address

## 19.

8/7/45  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... August 7 19 45, at 10:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
July 2 19 45, to August 7 19 45.  
 and that I last saw him alive on August 7 19 45.

## Immediate cause of death

Pulmonary Tuberculosis

## DURATION

4 Yrs.

## Due to

## Due to

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

## 23. SIGNATURE

M. D. Dr. J. H. BrownAddress State Sanatorium, Md. Date signed 8/8/45

RECEIVED  
AUG 10 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

08033

Reg. Diat. No. 140

## 1. PLACE OF DEATH:

County... FrederickCity or town... LeBoone  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution? .....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MD County... FrederickCity or town... LeBoone Rural  
(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3. (a) FULL NAME

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

B. (b) Name of husband or wife .....

7. Birth date of deceased (mo., day, yr.) July 25 - 1945 8. (c) If alive, give age ..... years8. AGE: Years 12 Months 12 Days 12 If less than one day ..... hrs. .... min.9. Birthplace... Emergency Hospital  
(town, county, and state)

10. Usual occupation .....

11. Industry or business .....

12. Name... Dorothy Young13. Birthplace... Frederick14. Maiden name... Betty Jane Hoff15. Birthplace... Woodsboro16. Informant... Betty Jane HoffAddress... LeBoone, Md.17. Burial Date thereof Aug 7, 1945  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory... Mt. Hope CemeteryLocation... Woodsboro Md18. Funeral director... Buell & HartylerAddress... Woodsboro Md19. Aug 7 19 45 J. C. Buell  
(Date recd by registrar) Registrar

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 6 19 45 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 5 - 19 45 to Aug. 6 19 45and that I last saw him alive on Aug 5 - 1945

Immediate cause of death.....

DURATION

Cholera Infantum 5 days

Due to.....

Due to.....

Other conditions .....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? .....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work?

23. SIGNATURE... J. H. Beall, M.D.

M. D. or other

Address... Libertytown Date signed Aug 6/45

STANDARD TELETYPE UNIT CHAIRMAN

STANDARD TELETYPE UNIT

RECEIVED

AUG 11 1945

BUREAU N.S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

## CERTIFICATE OF DEATH

Reg. Dist. No. 141

## I. PLACE OF DEATH:

County Fredrick  
 City or town Brunswick  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 da.  
 Hospital, institution, or street address where death occurred:  
Schnuffer Hospital  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia County Logan  
 City or town Paeonian Springs  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_ (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_ ✓

## 3. (a) FULL NAME

Phoebe E. Hood

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

E. M. Hood

## 7. Birth date of

deceased (mo., day, yr.)

Feb. 25 - 1868

## 5. (c) If alive, give age

48 years

## 8. AGE:

Years

Months

Days

If less than one day

7756

hrs.

min.

## B. Birthplace

Virginia

(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

None

## FATHER

## 12. Name

Wm. H. Hough

## 13. Birthplace

Virginia

## MOTHER

## 14. Maiden name

Hannah Williams

## 15. Birthplace

Virginia

## 16. Informant

Dr. E. M. Hood

## Address

Paeonian Springs Va

## 17.

(Burial, cremation, or removal, Which?)

## Date thereof

Aug 4 1945

## Cemetery or crematory

Waterford

## Location

Waterford Virginia

## 18. Funeral director

L. H. Fret & Son

## Address

Brunswick Md.

## 19.

(Date read by registrar)

Aug 23 1945Emma Martin

Reg. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August, 1, 1945 at 3:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July, 30, 1945 to Aug, 1, 1945and that I last saw her alive on Aug, 1, 1945

## Immediate cause of death

Cerebral Hemorrhage

## DURATION

10 days

## Due to

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

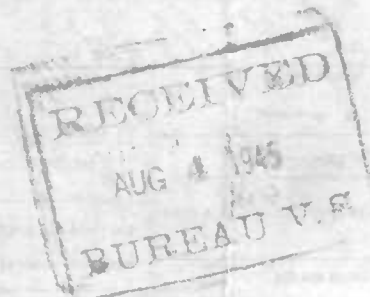
## 23. SIGNATURE

W. B. CarpenterM. D. August 23 1945Address Leesville, Va. Date signed 8/23/45



UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

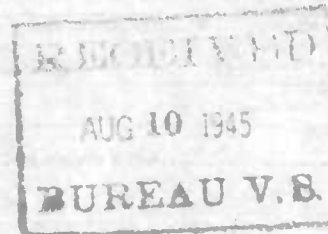


RECEIVED FOR RECORDS



UNITED STATES DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

## CERTIFICATE OF DEATH

Reg. Dist. No. 132

## 1. PLACE OF DEATH:

County Frederick  
 City or town Middletown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Frederick  
 City or town Middletown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

Lora Lighter Kefauver

## 3.(b) Social Security Number

220-18-1188

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced widowed  
 6.(b) Name of husband or wife Manville Kefauver  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) June 6, 1890  
 8. AGE: Years 55 Months 2 Days 0 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Middletown Frederick Co. Md.  
 (Town, county, and state)  
 10. Usual occupation Clerk Ration Board  
 11. Industry or business \_\_\_\_\_

FATHER 12. Name Daniel Lighter  
 13. Birthplace Middletown, Md.  
 MOTHER 14. Maiden name Annie Miller  
 15. Birthplace Middletown, Md.

16. Informant Miriam Krantz  
 Address Frederick, Md.

17. Burial Burial Date thereof 8-9-45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Reform Cemetery  
 Location Middletown, Md.

18. Funeral director Blodhill Co.  
 Address Middletown, Md.

19. Aug 9 1945 Marie Blodhill  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6 1945 at 11 A M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 5 1945 to Aug 6 1945  
 and that I last saw him alive on Aug 6 1945  
 Immediate cause of death \_\_\_\_\_

## DURATION

Cerebral Hemorrhage 24 hrs

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State) \_\_\_\_\_  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J E Harp Md  
 M. D. or other \_\_\_\_\_  
 Address Middletown Date signed 8-8-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
AUG 11 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

08037

Reg. Dist. No. 141

## 1. PLACE OF DEATH:

County... Fredmont  
 City or town... Brunswick  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs

Hospital, institution, or street address where death occurred:

112 West C St.How long in hospital or institution? —

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Baltimore

City or town... Brunswick  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 112 West C St.

(If rural, give LOCATION)

2(a) If veteran, name war —

## 3. (a) FULL NAME

Sallis Ruth Kinnis

## 3. (b) Social Security Number

4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced MarriedB. (b) Name of husband or wife Masses H Kinnis7. Birth date of deceased (mo., day, yr.) Mar 4 18535. (c) If alive, give age — years8. AGE: Years 92 Months 4 Days 29If less than one day — hrs. — min.9. Birthplace West Virginia

(Town, county, and state)

10. Usual occupation —11. Industry or business —12. Name Emanuel Miller13. Birthplace West Virginia14. Maiden name Anah Turner15. Birthplace West Virginia16. Informant Mrs. Wella C. H. FisherAddress Brunswick Md17. Buried Date thereof Aug 6 1945(Burial, cremation, or removal) Which ReposedCemetery or crematorium Shippensburg W Va.Location Shippensburg W Va.18. Funeral director C. H. Fisher & SonAddress Brunswick Md19. Aug 6 - 1945(Date read by registrar) Emanuel Miller

Date, Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 5 1945

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 7 1945, to Aug 5 1945and that I last saw him alive on Aug 2 1945Immediate cause of death Accidental fall

DURATION

24 hrsDue to Accidental fall & slipped on bedroom floorDue to —Other conditions Fractured right hipFractured July 7 1945

(Include pregnancy within 8 months of death)

Major findings of operations —Date of op. —Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of July 7 1945Where did injury occur? — (City or town) — (County) — (State)Injured at home, farm, industry, public place (where?) At homeMeans of injury Accidental fall Injured at work? —23. SIGNATURE — M. D. or other —Address — Date signed 8/5/45



RECEIVED  
JUN 8 1945  
BUREAU V.S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

## CERTIFICATE OF DEATH

 08038  
 ★ Reg. Dist. No. 131

## 1. PLACE OF DEATH:

 County Frederick  
 City or town Old Braddock  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 46 years  
 Hospital, institution, or street address where death occurred:  
Old Braddock  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

 State Md County Frederick  
 City or town Rural Old Braddock  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Old Braddock  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war none

## 3. (a) FULL NAME

Charles E. Klein

## 3. (b) Social Security Number

none
 4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

 6. (b) Name of husband or wife Senora Blanche Stoner  
 6. (c) If alive, give age 69 years

 7. Birth date of deceased (mo., day, yr.) June 6, 1866

 8. AGE: Years 79 Months 2 Days 1 If less than one day hrs. min.

 9. Birthplace Old Braddock, Frederick, Md  
 (Town, county, and state)
10. Usual occupation Farmer

## 11. Industry or business

 12. Name Samuel Klein  
 13. Birthplace Old Braddock

 14. Maiden name Elin. Smith  
 15. Birthplace Frederick, Co. Md

 16. Informant Mrs. Charles E. Klein  
 Address Old Braddock, Md

 17. Burial Date thereof Aug. 9, 1945  
 (Burial, cremation or somewhat) (month) (day) (year)

 Cemetery or Mt Olivet  
 Location Frederick, Md  
Harry G. Garty Co

 18. Funeral director Harry G. Garty Co  
 Address Frederick, Md

 19. 8 Aug 19 45 Elizabeth S. Heck  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

 20. DATE OF DEATH Aug 7 19 45 at 8:30 X M

 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17 Aug 19 45 and that I last saw him live on Aug 7 19 45

 Immediate cause of death Coronary occlusion DURATION 15 years

 Due to Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

 Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

 23. SIGNATURE W. W. Baur M. D. or other

 Address Frederick Date signed 8-7-45

DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH

RECEIVED  
AUG 10 1945  
BUREAU V.S.

MAILED 10  
AUG 10 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4)

## CERTIFICATE OF DEATH

08039

Reg. Dist. No. 131

## 1. PLACE OF DEATH:

County... Frederick  
 City or town... Frederick  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 35 years  
 Hospital, institution, or street address where death occurred:  
West 7th Street, Ext.  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Maryland County... Frederick  
 City or town... Frederick  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. West Seventh St., Ext.  
 (If rural, give LOCATION)  
 2.(c) If veteran, name war... None

## 3. (a) FULL NAME

NAOMI CORNELIA KREPPS

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) ~~Single~~ married, widowed, or divorced Married  
 6.(b) Name of husband or wife John Henry Krepps  
 7. Birth date of deceased (mo., day, yr.) January 16, 1878 8.(c) If alive, give age 66 years  
 8. AGE: Years 67 Months 6 Days 18 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace... Martinsburg, W. Va.  
 (Town, county, and state)  
 10. Usual occupation... Housewife  
 11. Industry or business None

FATHER 12. Name... Rev. Luther Nickels  
 13. Birthplace... Braddock, Maryland  
 MOTHER 14. Maiden name... Cornelia Schroyer  
 15. Birthplace... Braddock, Maryland

16. Informant... John H. Krepps  
 Address... Frederick, Maryland

17. Burial Date thereof... Aug. 6, 1945  
 (Burial, cremation, or removal) (month) (day) (year)  
 Cemetery or crematorium... Mt. Olivet Cemetery  
 Location... Frederick, Maryland

19. Funeral director... C. E. Cline & Son  
 Address... Frederick, Maryland

19. 6 Aug 1945 Elizabeth G Heck  
 (Date rec'd by Registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 4 1945 at 12:15 p  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16, 1945 to Aug 4, 1945  
 and that I last saw her alive on Aug 3, 1945

Immediate cause of death Cordial Apoplexy  
Hypertension  
 Due to 13 years  
 Due to stroke  
 Other conditions stroke  
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of .....  
 Where did injury occur? ..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) .....  
 Means of injury ..... Injured at work?

23. SIGNATURE F. H. Hegde M. D. or other ag 405  
 Address... Frederick Md Date signed 1945

UNITED STATES DEPARTMENT OF HEALTH

STATE OF TEXAS

RECEIVED  
JUL 8 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

08040

Reg. Dist. No. 131

## 1. PLACE OF DEATH:

County FrederickCity or town Frederick  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Frederick City Hospital

How long in hospital or institution?

3 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Frederick  
(If outside city or town limits, write RURAL and give nearest town)Street No. 35 East Church Street  
(If rural, give LOCATION)2.(a) If veteran, name war None

## 3.(a) FULL NAME

ANNIS ELIZABETH LANSDALE

## 3.(b) Social Security Number

None

4. Sex <u>F</u>	5. Color or race <u>W</u>	6.(a) Single, married, widowed, or divorced <u>M</u>
--------------------	------------------------------	---

B.(b) Name of husband or wife Dr. Philemon S. LansdaleB.(c) If alive, give age 62 years7. Birth date of deceased (mo., day, yr.) June 5, 1882

8. AGE:	Years	Months	Days	if less than one day
	<u>63</u>	<u>2</u>	<u>12</u>	<u>hrs.</u> <u>min.</u>

9. Birthplace Bristol, Virginia  
(Town, county, and state)10. Usual occupation At Home

11. Industry or business

FATHER	12. Name <u>Robert Pyle</u>
	13. Birthplace <u>Tennessee</u>

MOTHER	14. Maiden name <u>Mary Ledbetter</u>
	15. Birthplace <u>Virginia</u>

16. Informant Mr. Nelson Lansdale  
Address Frederick, Maryland17. Cremation Date thereof 8/20/45  
(If not, cremation, or removal, which?) (month) (day) (year)Location Fort Lincoln Crematory  
Washington, D. C.18. Funeral director M. R. Etchison and Son  
Address Frederick, Maryland19. 18 Aug 1945 Elizabeth G. Heck  
(Date rec'd by Registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 17th, 1945 at 2P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 14th, 1945 to August 17, 1945 and that I last saw her alive on August 17th, 1945Immediate cause of death Cerebral Hemorrhage

DURATION

3 Days

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Robert S. Pyle Md.

M. D. or other

Address Frederick, Maryland Date signed 8-18-45

CERTIFICATE OF DEATH

RECEIVED

AUG 21 1945

BUREAU OF



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH



Reg. Dist. No. 139

## 1. PLACE OF DEATH:

County..... **Frederick**  
 City or town..... **State Sanatorium, Maryland**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... **Since 5/24/42**  
 Hospital, institution, or street address where death occurred:  
**Maryland Tuberculosis Sanatorium**  
 How long in hospital or institution?..... **Since 5/24/42**

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... **Maryland** County.....  
 City or town..... **Baltimore**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. .... **3706 Spaulding Ave.**  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

**Patrick Maguire**

## 3. (b) Social Security Number

**215-16-5726**

## 4. Sex

**Male**

## 5. Color or race

**White**

## 6. (a) Single, married, widowed, or divorced

**Single**

## 6. (b) Name of husband or wife

## 7. Birth date of

deceased (mo., day, yr.)

**June 21, 1899**

6. (c) If alive, give age..... years

## 8. AGE:

Years

Months

Days

If less than one day

**46****2****3**

hrs.

min.

## 9. Birthplace

**Ireland**

(Town, county, and state)

## 10. Usual occupation

**Steam Fireman**

## 11. Industry or business

FATHER

## 12. Name

**Patrick Maguire**

## 13. Birthplace

**Ireland**

MOTHER

## 14. Maiden name

**Mary Longman**

## 15. Birthplace

**Ireland**

## 16. Informant

**Deceased**

## Address

## 17.

**Burial**  
(Burial, cremation, or removal. Which?)

## Date thereof

**Aug. 26, 1945**

## Cemetery or crematory

**Blue Ridge**

## Location

**Thurmont, Md.**

## 18. Funeral director

**M. L. Creager & Son**

## Address

**Thurmont, Maryland**

## 19.

**8/24/45**  
(Date rec'd by registrar)

19.....

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... **August 24**..... 19 **45**, at **4:10 A.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

**May 24**..... 19 **42**, to **Aug. 24**..... 19 **45**and that I last saw him alive on **August 24**..... 19 **45**

Immediate cause of death

**Pulmonary Tuberculosis**

DURATION

**7 Yrs.**~~xxxx~~ Complicated by:**Pott's Disease****4 Yrs.**~~xxxx~~ **Psoas Abscess****1 Yr.**

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. ....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?) .....

Means of injury

Injured at work?

23. SIGNATURE

**John H. Linschke M.D.**  
State Sanatorium, Md. Date signed **8/24/45**

RECEIVED  
AUG 25 1945  
BUREAU V.B.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

## CERTIFICATE OF DEATH

08042 131  
Reg. Diat. No.

1. PLACE OF DEATH:  
County Frederick  
City or town Frederick-Rural R. F. D. #3  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 35 years  
Hospital, institution, or street address where death occurred:  
Pleasant Hill  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Frederick  
City or town Frederick-Rural R. F. D. #3  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Pleasant Hill  
(If rural, give LOCATION)  
2(a) If veteran, name war None

3. (a) FULL NAME  
CLARA REBECCA MARTZ

3. (b) Social Security Number  
None

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced W

8. (b) Name of husband or George S. Martz  
B. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 2, 1867

8. AGE: Years 77 Months 10 Days 13 If less than one day hrs. min.

8. Birthplace Highland-Frederick-Maryland  
(Town, county, and state)

10. Usual occupation At Home

11. Industry or business

FATHER 12. Name Alias Warner  
13. Birthplace Frederick County Maryland

MOTHER 14. Maiden name Martha Ellen Green  
15. Birthplace Frederick County Maryland

16. Informant Miss Ethel V. Martz  
Address Frederick, Md. R. F. D. #3

17. Burial 8/17/45  
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)  
Cemetery or Mount Olivet Cemetery  
Location Frederick, Maryland

18. Funeral director M. R. Etchison and Son  
Address Frederick, Maryland

19. 16-Aug 1945  
(Date rec'd by registrar) Elizabeth G. Heck- Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH August 15th, 1945 at 9:55A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 31st 1945 to August 15, 1945  
and that I last saw h. er alive on August 15th, 1945

Immediate cause of death  
Arteriosclerosis  
Chronic Myocarditis  
Due to Cardiac Dilatation

DURATION  
10 Yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert L. Lacey M. D.

Address Frederick, Maryland Date signed 8-16-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

RECEIVED

RECEIVED  
AUG 18 1945  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

745

08043

## CERTIFICATE OF DEATH

★ Reg. Dist. No. 131

## 1. PLACE OF DEATH:

County FrederickCity or town Frederick  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 30 YearsHospital, institution, or street address where death occurred:  
704 East Patrick Street

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Frederick  
(If outside city or town limits, write RURAL and give nearest town)Street No. 704 East Patrick Street  
(If rural, give LOCATION)None

2.(a) If veteran, name war

## 3.(a) FULL NAME

BESSIE VICTORIA NUSBAUM

## 3.(b) Social Security Number

None

4. Sex <u>F</u>	5. Color or race <u>W</u>	6.(a) Single, married, widowed, or divorced <u>S</u>
--------------------	------------------------------	---

6.(b) Name of husband or wife

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) August 6, 1883

8. AGE: Years <u>62</u>	Months <u>0</u>	Days <u>19</u>	If less than one day .....hrs. ....min.
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8. Birthplace Mount Airy-Carroll-Maryland  
(Town, county, and state)10. Usual occupation At Home

11. Industry or business

FATHER	12. Name <u>Henry P. Nusbaum</u>
	13. Birthplace <u>Frederick County Maryland</u>

MOTHER	14. Maiden name <u>Sarah J. Snyder</u>
	15. Birthplace <u>Carroll County Maryland</u>

16. Informant Miss Ada Katharine Nusbaum  
Address 704 E. Patrick St., Frederick, Md.11. Burial 8/28/45  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mount Olivet Cemetery  
Frederick, Maryland  
Location18. Funeral director M. R. Etchison and Son  
Address Frederick, Maryland19. 27-Aug 1945 Elizabeth G. Heck  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 25, 1945 at 2:20 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 2 1945 to Aug 25 1945 and that I last saw him alive on August 25 1945Immediate cause of death Angina DURATION Aug. 24

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

23. SIGNATURE B. O. Thomas M. D.  
M. D. or otherAddress Frederick, Maryland Date signed 8-27-45

CERTIFICATE OF DEATH

RECEIVED  
AUG 29 1945  
BUREAU - F



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

## CERTIFICATE OF DEATH

Reg. Diat. No. 08044 131

## 1. PLACE OF DEATH:

County FrederickCity or town Frederick  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 11 mos

Hospital, institution, or street address where death occurred:

Frederick City HospitalHow long in hospital or institution? 11 mos

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Wickerson  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war. \_\_\_\_\_

## 3. (a) FULL NAME

BABY BOY PAINTER

## 3. (b) Social Security Number

none

## 4. Sex

male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

single

## 6. (b) Name of husband or wife

## 7. Birth date of

deceased (mo., day, yr.)

Aug 25

B. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

00011 hrs.35 min.

## 9. Birthplace

Wickerson, Montg. Co., Md.  
(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

## FATHER

## 12. Name

## 13. Birthplace

## MOTHER

## 14. Maiden name

## 15. Birthplace

## 16. Informant

## Address

## 17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

## Cemetery or crematory

## Location

## 18. Funeral director

## Address

## 19.

26 Aug '45  
(Date rec'd by Registrar)19. 45Elizabeth G. Heck

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 - 1945 at 1:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

8/25 - 1945 to 8/25 - 1945  
and that I last saw him alive on 8/25 - 1945

Immediate cause of death

Premature birth (6 mos)

## DURATION

12 hrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury

Injured at work?

23. SIGNATURE

B. S. White, M.D.

M. D. or other

Address Poolesville, Md. Date signed 8/25/45

RECEIVED

AUG 29 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 119

08045

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

## 1. PLACE OF DEATH:

County FrederickCity or town Frederick Rural  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER  
MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. 7-Aug

(Date rec'd by registrar)

19 45

Elizabeth G. Heck

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH

August 5, 1945 at 6:15 P M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

August 1, 1945 to Aug. 5, 1945and that I last saw him alive on 8/5/45 19

Immediate cause of death

Enteritis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed 8-6-45

UNITED STATES DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH

RECEIVED  
AUG 9 1945  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:  
 County Frederick  
 City or town Frederick  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Lifetime  
 Hospital, institution, or street address where death occurred: Frederick City Hospital  
 How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Frederick  
 City or town Middletown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

3.(a) FULL NAME Anna Clarens Shank 3.(b) Social Security Number None

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of husband or wife Chas. M. Shank  
 7. Birth date of deceased (mo., day, yr.) 3-12-1864  
 6.(c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 81 Months 4 Days 27 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Frederick Co. Md.  
 (Town, county, and state)  
 10. Usual occupation Retired Housewife  
 11. Industry or business \_\_\_\_\_  
 12. Name Henry Keller  
 13. Birthplace Frederick Co. Md.  
 14. Maiden name Sarah Biser  
 15. Birthplace Frederick Co. Md.

16. Informant Miss Catherine Alexander  
 Address Middletown - Md.  
 17. Buried Exhumed Removed 8-11-45  
 (Burial, cremation, or removal, which?) Date thereof (month) (day) (year)  
 Cemetery or crematory Reformed Cemetery  
 Location Middletown - Md.  
 18. Funeral director C. E. Cline & Son  
 Address Frederick - Md.

19. 11 Aug 19 45 Elizabeth G. Heck  
 (Date rec'd by Registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 8 - 1945 8:45 a.m.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 3 1945 to Aug 8 1945  
 and that I last saw him alive on Aug 8 1945

Immediate cause of death \_\_\_\_\_ DURATION 15 min  
Pulmonary Embolism  
 Due to Post-operative venous thrombosis 2 days  
 Due to Ovarian cyst & twisted pedicle 7 wks  
 Other conditions Arterio-sclerosis ?  
 (Include pregnancy within 3 months of death)  
 Major findings of operations Ovarian cyst & twisted pedicle  
 Dates of op. Aug 6 & 7, 1945  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Frank L. Worthington  
 M. D. or other \_\_\_\_\_  
 Address Frederick - Md Date signed Aug 10, 1945

RECEIVED

AUG 13 1945

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 139

08047-139  
Reg. Dist. No. 74-139

## 1. PLACE OF DEATH:

County... Frederick

City or town... Sabillasville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution? :

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new born infants give residence of mother)

State... MD County... Frederick

City or town... Sabillasville  
(If outside city or town limits, write RURAL and give nearest town)Street No. :  
(If rural, give LOCATION)

2.(a) If veteran, name war... No

## 3.(a) FULL NAME

Edward Columbus Shriner

## 3.(b) Social Security Number

No

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife... Ellen Mc Clain

6.(c) If alive, give age : years

7. Birth date of deceased (mo., day, yr.) Jan. 16th. 1858

8. AGE: Years Months Days If less than one day

87

7

12

: hrs. : min.

9. Birthplace... Sabillasville MD  
(Town, county, and state)

10. Usual occupation... Retired

## 11. Industry or business

12. Name... Manuel Shriner

13. Birthplace... Md

14. Maiden name... Adaline Wetzel

15. Birthplace... Md

16. Informant... Morris Clark

Address... Sabillasville. Md

17. Burial Date thereof... Aug. 30. 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Otterbrein? Chapel

Location... Nr Sabillasville. Md

18. Funeral director... M. L. Creager &amp; Son

Address... Thurmont. MD.

19. Aug. 30 1945 - Blanche S. Eyles

(Date typed by registrar) Deputy Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 27th 1945 1945 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10 1945 to 8-28-45

and that I last saw him alive on 8-28-45

Immediate cause of death : Chronic Myocardial

DURATION

Due to : :

Due to : :

Due to : :

Due to : :

Due to : :

Other conditions : :

(Include pregnancy within 3 months of death)

Major findings of operations : :

Date of op. : :

Autopsy results : :

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. : Date of : :

Where did injury occur? : (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) : :

Means of injury : Injured at work? :

23. SIGNATURE : H.C. Bridgman

Date : 8-30-45

Address : :

RECEIVED BY THE BUREAU OF INVESTIGATION

CERTIFICATE OF DEATH

RECEIVED BY THE BUREAU OF INVESTIGATION

RECEIVED  
SEP 6 1945  
BUREAU V.S.

POST OFFICE DEPARTMENT

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

08948

Reg. Dist. No. 131

## 1. PLACE OF DEATH:

County... Frederick  
 City or town... Frederick  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 65 years  
 Hospital, institution, or street address where death occurred:  
 Emergency Hospital  
 How long in hospital or institution? 1 day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Maryland County... Frederick  
 City or town... Frederick  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 130 East 4th. Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war... None

## 3. (a) FULL NAME

ALICE VIRGINIA SMITH

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband John P. Smith  
 6. (c) If alive, give age... years  
 7. Birth date of deceased (mo., day, yr.) November 15-1860

8. AGE: Years Months Days If less than one day  
 84 9 16 hrs. min.

9. Birthplace Washington County Maryland  
 (Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business

FATHER 12. Name Samuel Stottlemeyer  
 13. Birthplace Washington County Maryland

MOTHER 14. Maiden name Don't Know  
 15. Birthplace Don't Know

16. Informant Mrs. Gertrude Rickards  
 Address 130 E. 4th. St.-Frederick, Md.

17. Burial Date thereof Sept. 3-1945  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory St. Johns Cemetery  
 Location Frederick, Md.

18. Funeral director C.E. Cline and Son  
 Address Frederick, Md.

19. 2 Sept 1945 Elizabeth G. Heide  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 31- 1945, at 2:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 28 1945, to Aug. 31 1945  
 and that I last saw him alive on Aug. 29 1945

Immediate cause of death

Carcinoma of Stomach

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. Harp M.D.

M. D. or other

Address Frederick, Md. Date signed 9-1-45

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

RECEIVED

SEP 5 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

08049

Reg. Dist. No. 131

## 1. PLACE OF DEATH:

County FrederickCity or town Frederick Rural  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widower

6. (b) Name of husband or wife

Ida May Bitler

7. Birth date of

deceased (mo., day, yr.)

September 14, 1872

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

if less than one day

721024

.....hrs. ....min.

9. Birthplace

Nr. Johnsville-Frederick-Md.

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

FATHER

12. Name

Daniel D. Smith

13. Birthplace

Frederick County Maryland

MOTHER

14. Maiden name

Mary Kinny

15. Birthplace

Frederick County Maryland

16. Informant

Mrs. Mary A. Long

Address

212 E. 5th St., Frederick, Md.

17.

BurialDate thereof 8/10/45

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or ~~removal~~Glade Cemetery

Location

Walkersville, Maryland

18. Funeral director

M. R. Etchison and Son

Address

Frederick, Maryland

19.

9-Aug

19

45Elizabeth G. Hech

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town

Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No.

212 E. 5th

(If rural, give LOCATION)

2. (a) If veteran, name war

None

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 8

19

45 at 2:40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

same

19

45

and that I last saw him alive on

Aug 7

19

45

Immediate cause of death

Cardio-Renal-Vascular Disease

DURATION

2 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

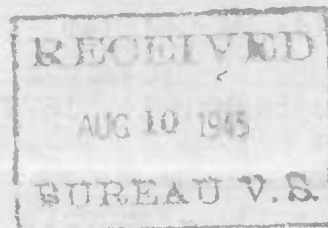
23. SIGNATURE

M. D. or other

Address

Date signed

8-8-45





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

 08050  
 ★ Reg. Dist. No. 131

## 1. PLACE OF DEATH:

 County Frederick  
 City or town Frederick  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Frederick City Hospital

How long in hospital or institution?

4 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

 State Maryland County Frederick  
 City or town Jefferson  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

None

## 3. (a) FULL NAME

NELLIE VIRGINIA SMITH

## 3. (b) Social Security Number

None

4. Sex

F

5. Color or race

W6. (a) ~~Single~~, married, widowed, or divorcedM

6. (b) Name of husband or wife

George W. Smith6. (c) If alive, give age 58 years

7. Birth date of

deceased (mo., day, yr.)

July 11, 1888

8. AGE:

Years

Months

Days

If less than one day

5711

.....hrs.

.....min.

9. Birthplace

Nr. Jefferson-Frederick-Maryland

(Town, county, and state)

10. Usual occupation

At Home

11. Industry or business

FATHER

12. Name

John W. Pearl

13. Birthplace

Frederick County Maryland

MOTHER

14. Maiden name

Lillie Waskey

15. Birthplace

Frederick County Maryland

16. Informant

Mr. George W. Smith

Address

Jefferson, Maryland

17.

Burial

Date thereof

8/14/45

(Burial, cremation, or removal-Which?)

(month) (day) (year)

Cemetery or crematory

St. Pauls Lutheran Cemetery

Location

Jefferson, Maryland

18. Funeral director

M. R. Etchison and Son

Address

Frederick, Maryland

19.

13-Aug1945

(Date rec'd by registrar)

Elizabeth B. Heck

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 121945

at

7A

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 81945to Aug 121945and that I last saw him alive on Aug 121945

Immediate cause of death

M. yocardial degeneration

DURATION

3 Days

Due to

Acute Spinal Cord Lesion  
& Chronic Myocarditis5 Days  
10 Days

Due to

Obesity extreme

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

C. D. Leland, M.D.

M. D. or other

Address

Jefferson

Date signed

8/14/45

RECEIVED

DEC 14 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-2)

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:  
 County Frederick  
 City or town Jefferson - Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 7 Years  
 Hospital, institution, or street address where death occurred:  
Near Jefferson  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Frederick  
 City or town Jefferson - Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Near Jefferson  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

3. (a) FULL NAME  
ALBERTA CATHERINE SOUDER

3. (b) Social Security Number  
None

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced W  
 B. (b) Name of husband or wife George M. Souder  
 B. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) July 29, 1871  
 8. AGE: Years 74 Months 0 Days 21 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Lovettsville-Loudoun-Virginia  
 (Town, county, and state)  
 10. Usual occupation At Home  
 11. Industry or business

12. Name Jonas Slater  
 13. Birthplace Loudoun County Virginia  
 14. Maiden name Ellen Stoneburner  
 15. Birthplace Loudoun County Virginia

16. Informant Mr. Raymond R. Souder  
 Address Jefferson, Maryland

17. Burial Date thereof 8/23/45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
Union Cemetery  
 Cemetery or crematory  
Lovettsville, Virginia  
 Location

18. Funeral director M. R. Etchison and Son  
 Address Frederick, Maryland

19. August 22, 1945 Elizabeth H. Heck  
 (Date rec'd by registrar) (Signature) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 20th, 1945 at 11:30 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 26 1945 to Aug 20 1945 and that I last saw him alive on Aug 18 1945

Immediate cause of death Myocardial Infarction DURATION 2 1/2 hrs  
 Due to Arteriosclerosis  
 Due to \_\_\_\_\_  
 Other conditions 1

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Elizabeth H. Heck M. D.  
Brunswick, Maryland M. D. or other  
 Address \_\_\_\_\_ Date signed 8-21-45

UNITED STATES DEPARTMENT OF JUSTICE

STANDARD MAIL

RECEIVED

AUG 24 1945

BUREAU V.B.



RECEIVED

AUG 8 1945

BUREAU V.S.

lv Tskney



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 89

08053

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

## 1. PLACE OF DEATH:

County Frederick  
 City or town Frederick-Rural R. F. D. #1  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 8 Years  
 Hospital, institution, or street address where death occurred:  
I. O. O. F. Home  
 How long in hospital or institution? 8 Years

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Frederick  
 City or town Thurmont  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
None  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

JAMES HENRY STOKES

## 3. (b) Social Security Number

None

4. Sex <u>M</u>	5. Color or race <u>W</u>	6. (a) Single, married, widowed, or divorced <u>S</u>
--------------------	------------------------------	--

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) April 15, 1862  
 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE:	Years	Months	Days	If less than one day
	<u>83</u>	<u>4</u>	<u>2</u>	_____ hrs. _____ min.

9. Birthplace Frederick County Maryland  
 (Town, county, and state)

10. Usual occupation Cigar Maker

## 11. Industry or business

12. Name Joshua Stokes13. Birthplace Frederick County Maryland14. Maiden name Anna Catherine Weller15. Birthplace Frederick County Maryland16. Informant I. O. O. Home RecordsAddress Frederick, Md. R. F. D. #117. Burial Date thereof 8/20/45

(Burial, cremation, or removal, which) (month) (day) (year)

Cemetery or location United Brethren CemeteryLocation Thurmont, Maryland18. Funeral director M. R. Etchison and SonAddress Frederick, Maryland19. 18 Aug 1945 Elizabeth G. Hecker

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 17, 1945 at 5:25 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 5 1945 to Aug 17 1945and that I last saw him alive on Aug 17 1945

Immediate cause of death \_\_\_\_\_

DURATION 12 daysDue to Cerebral stem infarctDue to Septic pneumonia

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations None

Date of op. \_\_\_\_\_

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE A. Arthur Casse M. D.Address Frederick, Maryland Date signed 8-18-45

CERTIFICATE OF DEATH

RECEIVED  
AUG 21 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

08054/31  
Reg. Dist. No. ....

<b>1. PLACE OF DEATH:</b> County..... <u>Frederick</u> City or town..... <u>Frederick</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <u>Lifetime</u> Hospital, institution, or street address where death occurred: <u>Frederick City Hospital</u> How long in hospital or institution?..... <u>7 days</u>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State..... <u>Maryland</u> County..... <u>Frederick</u> City or town..... <u>near Mt. Airy</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... (If rural, give LOCATION) 2.(a) If veteran, name war..... <u>None</u>													
<b>3. (a) FULL NAME</b> <u>FANNIE E. SUMMERS</u>				<b>3. (b) Social Security Number</b> <u>None</u>													
<b>4. Sex</b> <u>Female</u>		<b>5. Color or race</b> <u>White</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>Widowed</u>													
<b>6. (b) Name of husband or wife</b> <u>Jonas V. Summers</u>				<b>6. (c) If alive, give age</b> ..... years													
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>January 25-1865</u>				<b>8. AGE:</b> <table border="1"> <tr> <td>Years</td> <td>Months</td> <td>Days</td> <td colspan="2">if less than one day</td> </tr> <tr> <td><u>80</u></td> <td><u>6</u></td> <td><u>15</u></td> <td>.....hrs.</td> <td>.....min.</td> </tr> </table>				Years	Months	Days	if less than one day		<u>80</u>	<u>6</u>	<u>15</u>	.....hrs.	.....min.
Years	Months	Days	if less than one day														
<u>80</u>	<u>6</u>	<u>15</u>	.....hrs.	.....min.													
<b>9. Birthplace</b> <u>Middletown Valley- Maryland</u> (Town, county, and state)				<b>10. Usual occupation</b> <u>Retired Housewife</u>													
<b>11. Industry or business</b>				<b>12. Name</b> <u>James H. Joy</u>													
<b>13. Birthplace</b> <u>Frederick County Maryland</u>				<b>14. Maiden name</b> <u>Rosa Measell</u>													
<b>15. Birthplace</b> <u>Frederick County Maryland</u>				<b>16. Informant</b> <u>Mrs. Charles H. Kehne</u> Address <u>near Mt. Airy- Md.</u>													
<b>17. Burial</b> (Burial, cremation, or removal) Which?..... Date thereof..... <u>August 13-45</u> (month) (day) (year) Cemetery or crematory..... <u>Mount Olivet Cemetery</u> Location..... <u>Frederick, Maryland</u>				<b>18. Funeral director</b> <u>C.E. Cline and Son</u> Address <u>Frederick, Maryland</u>													
<b>19. 11 Aug 1945</b> (Date rec'd by registrar)				<b>20. Signature</b> <u>Elizabeth G. Heck</u> Registrar													

MEDICAL CERTIFICATION	
<b>2D. DATE OF DEATH</b> <u>August 9th.</u> 19 <u>45</u> at <u>10:30p.m.</u>	<b>21. I CERTIFY</b> that death occurred on the date above stated; that I attended deceased from <u>Aug 4</u> 19 <u>45</u> , to <u>Aug 9</u> 19 <u>45</u> and that I last saw her alive on <u>Aug 9</u> 19 <u>45</u>
<b>Immediate cause of death</b> <u>myocarditis</u> <u>atherosclerosis</u>	<b>DURATION</b> <u>2 wks</u>
<b>Other conditions</b> <u>None</u>	<b>Major findings of operations</b> <u>None</u>
<b>Autopsy results</b> <b>PHYSICIAN: Please underline the cause to which death should be charged statistically.</b>	
<b>22. VIOLENCE: If death was due to external causes, fill in the following:</b> Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town) (County) (State) Injured at home, farm, industry, public place (where?)..... Means of injury..... injured at work?	
<b>23. SIGNATURE</b> <u>W. P. Thomas</u> Address <u>Frederick Md</u> Date signed <u>Aug 10 1945</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

AUG 13 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

08055

★ Reg. Dist. No. 131

## 1. PLACE OF DEATH:

County Frederick  
 City or town Frederick  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 hours  
 Hospital, institution, or street address where death occurred:  
320 Chapel Alley  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Frederick  
 City or town Ceresville - Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

BERNARD THOMAS TOBERY

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single  
 6.(b) Name of husband or wife \_\_\_\_\_  
 7. Birth date of deceased (mo., day, yr.) August 9, 1945 6.(c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 9 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Frederick, Frederick Co., Md.  
 (Town, county, and state)  
 10. Usual occupation Infant  
 11. Industry or business \_\_\_\_\_

12. Name Arthur G. Tobery  
 13. Birthplace Frederick County, Maryland  
 14. Maiden name Florence Wetzel  
 15. Birthplace Frederick, Maryland

16. Informant Arthur G. Tobery  
 Address Ceresville, Maryland

17. Burial Date thereof August 20, 1945  
 (Burial, cremation, or removal. Which) (month) (day) (year)  
 Cemetery or crematory Mt. Olivet Cemetery  
 Location Frederick, Maryland

18. Funeral director C. E. Cline & Son  
 Address Frederick, Maryland

19. 20 Aug 19 45 Elizabeth G. Heck  
 (Date rec'd by Registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 18 19 45 at 1:50p M  
 21. CERTIFY that death occurred on the date above stated; that it attended deceased from Aug 9 19 45 to Aug 18 19 45  
 and that I last saw him/her alive on Aug 18 19 45  
 Immediate cause of death Alactosis  
 Due to Immaturity  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Elizabeth G. Heck M. D. or other \_\_\_\_\_  
 Address Ceresville Date signed 8/18/45

UNITED STATES DEPARTMENT OF JUSTICE

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

RECEIVED  
AUG 21 1945  
BUREAU V.R.



changes of items 1, 2a, 6c, 17, 21 and 22: new cer. signed by Dr. Baer, with letter from wife, filmed G89  
10-15-45. L

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 169

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

County Frederick  
City or town Frederick  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
Frederick City Hospital  
How long in hospital or institution? Immediate

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 710 Chestnut Street  
(If rural, give LOCATION)  
2.(a) If veteran, name war None Yes; War II ☒

3. (a) FULL NAME

Mr Clyde Trumppower

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife Mrs Madeline Trumppower  
7. Birth date of deceased (mo., day, yr.) August - 30 - 1905  
6. (c) If alive, give age 40 years

8. AGE: Years 39 Months 11 Days 22 If less than one day  
.....hrs. ....min.

9. Birthplace Clearspring - Wash. C. - Md.  
(Town, county, and state)

10. Usual occupation Blackman

11. Industry or business W. M. R. R.

12. Name Jeremiah Trumppower

13. Birthplace Clearspring

14. Maiden name Estelle Kinsell

15. Birthplace Clear Springs - Md.

16. Informant MRS. Madeline Trumppower

Address Hagerstown - Md.

17. Burial Date thereof Aug - 24 - 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown - Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown - Md.

19. Aug 22 - 1945 Elizabeth G. Decker  
(Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 22 19 45 at 5:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h. 19 Aug 22 19 45

Immediate cause of death Fracture of skull  
and evacuation of brain

Due to Fall from B&O R.R.  
car

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 8.21.45

Where did injury occur? Hagerstown, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) B&O R.R.

Means of injury Fall from car Injured at work? yes

23. SIGNATURE R. W. Baer M. D. or other

Address Frederick, Md. Date signed 8.22.45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 27 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *1228*

## CERTIFICATE OF DEATH

08057

★ Reg. Dist. No. *131*

## 1. PLACE OF DEATH:

County Frederick  
 City or town Frederick  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Lifetime  
 Hospital, institution, or street address where death occurred:  
Frederick City Hospital  
 How long in hospital or institution? 2 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Frederick  
 City or town Frederick  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 9 E. 2nd. St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

ANNA LOUISE VAN SWEARINGEN

## 3. (b) Social Security Number

214-10-2624

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6.(a) <del>Single</del> married, widowed, or divorced <u>Married</u>
6.(b) Name of husband or <del>husband</del> <u>Charles Van Swearingen</u>		
6.(c) If alive, give age <u>46</u> years		
7. Birth date of deceased (mo., day, yr.) <u>June 30-1905</u>		
8. AGE: Years <u>40</u>	Months <u>1</u>	Days <u>20</u> hrs. min.

9. Birthplace Woodsboro Frederick Co. Md.  
 (Town, county, and state)  
 10. Usual occupation Billing Clerk  
 11. Industry or business G.L.Baking Co.

FATHER	12. Name <u>Charles J.F. Miller</u>
	13. Birthplace <u>Frederick Co. Md.</u>
MOTHER	14. Maiden name <u>Minnie A. Delaplane</u>
	15. Birthplace <u>Frederick Co. Md.</u>

16. Informant Charles Van Swearingen  
 Address 9 E. 2nd. St.-Frederick, Md.

17. Burial  
 (Burial, cremation, or removal. Which?) Date thereof August 22-45  
 (month) (day) (year)  
 Cemetery or crematorium Mount Olivet Cemetery  
 Location Frederick, Md.

18. Funeral director C.E.Cline and Son  
 Address Frederick, Md.

19. 20 Aug 19 45  
 (Date rec'd by registrar) Elizabeth B. Heck  
 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 19th. 19 45 at 11:35a

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 17 8:5 to Aug 19 8:5  
 and that I last saw her alive on Aug 19 8:5

Immediate cause of death Myocarditis  
 Due to 3 days  
 Due to Partial Intest Obstruction  
 Other conditions Partial Intest Obstruction  
 (Include pregnancy within 8 months of death)

Major findings of operations —  
 Date of op. —  
 Autopsy results —  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide — Date of —  
 Where did injury occur? — (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) —  
 Means of injury — Injured at work? —

23. SIGNATURE EP Thomas  
 Address Frederick, Md. Date signed Aug 20 45  
 M. D. or other

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED  
AUG 21 1945  
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08058

## CERTIFICATE OF DEATH

★ Reg. Dist. No. 131

1. PLACE OF DEATH:  
 County Frederick  
 City or town Frederick-Rural R. F. D. #3  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 20 years  
 Hospital, institution, or street address where death occurred:  
Near Rocky Spring  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Frederick  
 City or town Frederick-Rural R. F. D. #3  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Near Rocky Spring  
 (If rural, give LOCATION)  
 2.(u) If veteran, name war None

## 3. (a) FULL NAME

ROSIE MAY WACHTER

3. (b) Social Security Number  
None

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced M  
 6. (b) Name of husband or wife Cornelius A. Wachter  
 6. (c) If alive, give age 71 years  
 7. Birth date of deceased (mo., day, yr.) May 10, 1875  
 8. AGE: Year 70 Months 3 Days 2 It less than one day  
 hrs. min.

9. Birthplace Frederick County Maryland  
 (Town, county, and state)  
 10. Usual occupation At Home  
 11. Industry or business

FATHER 12. Name Joseph Engle  
 13. Birthplace Frederick County Maryland  
 MOTHER 14. Maiden name Margaret Hinea  
 15. Birthplace Frederick County Maryland  
 16. Informant Mr. Cornelius Wachter  
 Address R. F. D. #3, Frederick, Maryland  
 17. Burial Burial Date thereof 8/15/45  
 (Burial, cremation, or removal, which?) (month) (day) (year)  
 Cemetery or crematory Brookhill Cemetery  
 Location Yellow Spring, Maryland  
 18. Funeral director M. R. Etchison and Son  
 Address Frederick, Maryland  
 19. 14 Aug 19 45 Elizabeth G. Heck  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 12th, 1945 at 8 P M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
August 10th 1945 to Aug 12th 1945  
 and that I last saw h.e.r. alive on Aug 12 1945  
 Immediate cause of death Cerebral Haemorrhage DURATION 1 Week  
 Due to Cerebral Haemorrhage  
 Due to 1 21  
 Other conditions none.  
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?

23. SIGNATURE H. F. Gelfand M. D.  
 Address Frederick, Maryland Date signed 8-14-45

CERTIFICATE OF DEATH

RECEIVED

AUG 16 1945

BUREAU V S



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 82

## CERTIFICATE OF DEATH

Reg. Dist. No. 08059 144

## 1. PLACE OF DEATH:

County... *Fredrick*City or town... *Thurmont*  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *7 days*  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... *Maryland* County... *Fredrick*City or town... *Thurmont*  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)2. (a) If veteran, name war *210*

## 3. (a) FULL NAME

*Gertrude Delphine Wastler*

## 3. (b) Social Security Number

*none*

4. Sex

*Female*

5. Color or race

*White*

6. (a) Single, married, widowed, or divorced

*Widowed*

6. (b) Name of husband or wife

*Romance Wastler*

7. Birth date of deceased (mo., day, yr.)

*June 21, 1876*

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years

Months

Days

If less than one day

*69**21**0*

hrs.

min.

9. Birthplace

*Washington, D.C.*  
(Town, county, and state)

10. Usual occupation

*Housewife*

11. Industry or business

MOTHER

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial (Burial, cremation, or removal. Which?)

Date thereof *Aug 23, 1945*  
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. *Aug 23* 19 *45*  
(Date rec'd by registrar)*Blanche S. Eyles*  
*Deputy Registrar*

## MEDICAL CERTIFICATION

20. DATE OF DEATH *August 28, 1945* at *9 A.* M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Aug 21 - 1945* to *Aug 21 - 1945*  
and that I last saw him alive on *July 15 - 1945*

Immediate cause of death

*Cerebral Hemorrhage*

DURATION

*Sudden*

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

M. D. or other

Date signed *8/23/45*

CERTIFICATE OF DEATH

STATE OF MASSACHUSETTS

RECEIVED  
AUG 27 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1619

68060

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH: Frederick  
 County.....  
Brunswick  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 7 days  
 Hospital, institution, or street address where death occurred:  
Schnauffer Hospital  
 How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Wenton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... ☒

## 3. (a) FULL NAME

Wayne Eugene Webber

## 3. (b) Social Security Number

—

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Single  
 6. (b) Name of husband or wife.....  
 7. Birth date of deceased (mo., day, yr.) May 18 1945 8. (c) If alive, give age..... years  
 8. AGE: Years Months Days If less than one day  
2 29 ..... hrs. .... min.

9. Birthplace Maryland  
 (Town, county, and state)

10. Usual occupation.....

## 11. Industry or business

12. Name Paul S. Webber  
 13. Birthplace Maryland  
 14. Maiden name Virginia Phillips  
 15. Birthplace Maryland

16. Informant Mrs. P. S. Webber  
 Address Wenton, Md.

17. Burial Date thereof Aug 19 1945  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Church of Brethren Cemetery  
 Location Brownsville, Md.

18. Funeral director C. W. Teate & Bros  
 Address Brunswick, Md.

19. Aug 19-1945 Ernesta Martin  
 (Date rec'd by registrar) (Signature) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 17 19 45, at 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 11 19 45, to Aug 17 19 45.

and that I last saw him alive on Aug 17 19 45.

Immediate cause of death Exhaustion

Due to Anhydremia

Due to.....

Due to.....

Other conditions.....

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RECEIVED  
AUG 21 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

08061

★ Reg. Dist. No. 131

1. PLACE OF DEATH:  
 County Frederick  
 City or Frederick  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
Frederick City Hospital  
 How long in hospital or institution? 3 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Frederick  
 City or town Frederick-Rural R. F. D. #4  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Sunnyside  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

DOCTOR ILE WEEDON

## 3. (b) Social Security Number

None

4. Sex M 5. Color or race C 6.(a) Single, married, widowed, or divorced M  
 B.(b) Name of husband or wife Cecelia F. Scott  
 7. Birth date of deceased (mo., day, yr.) September 15, 1892 8.(c) If alive, give age 47 years  
 8. AGE: Years 52 Months 10 Days 27 If less than one day  
 .....hrs. ....min.

9. Birthplace Nr. Jefferson-Frederick-Maryland  
 (Town, county, and state)

10. Usual occupation Orderly

11. Industry or business Frederick City Hospital

FATHER 12. Name Henry A. Weedon  
 13. Birthplace Frederick County Maryland

MOTHER 14. Maiden name Alverta Layer  
 15. Birthplace Frederick County Maryland

16. Informant Mrs. Cecelia S. Weedon  
 Address R. F. D. #4, Frederick, Md.

17. Burial 8/15/45 Date thereof (month) (day) (year)  
 (Burial, cremation, or removal, which?)  
 Cemetery or crematory Sunnyside Methodist Cemetery  
 Location Near Jefferson, Maryland

18. Funeral director M. R. Etchison and Son  
 Address Frederick, Maryland

19. 14 Aug 1945 Elizabeth G. Heck  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 12th, 1945 at 10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 .....19..... to .....19.....  
 and that I last saw him in DEAD August 12th, 1945

Immediate cause of death  
Compressed fracture  
2 thoracic vertebrae  
 Due to Causing complete  
paralysis from that  
 Due to joint to lower extremities  
 Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 .....Date of op. ....  
 Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Accident Date of 8-8-45  
 Where did injury occur? Nr. Jefferson-Frederick-Md.  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) Farm  
 Means of Injury Fell from Straw Stack Yes

23. SIGNATURE R. Thomas  
Physician Medical Examiner M.D. or other  
Frederick, Maryland Date signed 8-13-45  
 Address

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

AUG 16 1945

BUREAU V.S.





CERTIFICATE OF DEATH

RECEIVED  
AUG 18 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 302

## CERTIFICATE OF DEATH

08068

Reg. Dist. No. 131

## 1. PLACE OF DEATH:

County FrederickCity or town Frederick  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 23 days

Hospital, institution, or street address where death occurred:

Frederick County JailHow long in hospital or institution? 23 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Potomac  
(If outside city or town limits, write RURAL and give nearest town)Street No. Forest Lane

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

Virginia W Whitman

## 3.(b) Social Security Number

4. Sex Female5. Color or race White6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Ronald W Whitman6.(c) If alive, give age 35 years7. Birth date of deceased (mo., day, yr.) Sept 23 - 19128. AGE: Years 32 Months 11 Days 1 If less than one day

hrs. min.

8. Birthplace Maryland

(Town, county, and state)

10. Usual occupation None11. Industry or business None12. Name Alma Tucker13. Birthplace Maryland14. Maiden name Martha E. Gross15. Birthplace Maryland18. Informant Russell H. FinkleAddress Potomac Md17. Burial Date thereof Aug 26 1945

(Burial, cremation, or other) (month) (day) (year)

Cemetery or crematory Forest LaneLocation near Potomac - Washington Co.18. Funeral director B. H. Finkle & SonAddress Baltimore Md19. 24 Aug 1945 Elizabeth G Heck

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 24 1945 at 3 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw her dead on Aug 24 1945Immediate cause of death Unknown

DURATION

Due to

Due to

Other conditions Deceased was known to havehad lues

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results Cause of death unknown

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P. W. Baw. Dep. Med. Ex.Sept 11, 1945 M. D. or otherAddress Forest Lane Date signed 9-11-45

STATE OF TEXAS STATE CHARTER

STATE OF TEXAS

RECEIVED

SEP 13 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 16420

## CERTIFICATE OF DEATH

Reg. Dist. No. 08064 131

## 1. PLACE OF DEATH:

County... Frederick  
 City or town... Walkersville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 months  
 Hospital, institution, or street address where death occurred:  
 Fulton Ave.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Md. County... Frederick  
 City or town... Walkersville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... Fulton Ave.  
 (If rural, give LOCATION)  
 2(a) If veteran, name war -

## 3. (a) FULL NAME

Nellie R. Yessler

## 3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced - widowed

6. (b) Name of husband or wife Harry Yessler

7. Birth date of deceased (mo., day, yr.) February 13, 1874 8. (c) If alive, give age years

8. AGE: Years 71 Months 6 Days 15 hrs. min.

9. Birthplace Rocky Ridge, Fred. Co., Md.  
 (Town, county, and state)

10. Usual occupation -

11. Industry or business -

12. Name Daniel Edward Martin

13. Birthplace Frederick Co., Md.

14. Maiden name Sarah M. Crouse

15. Birthplace Frederick Co., Md.

16. Informant Miss Effie Martin

Address Philadelphia, Penna.

17. Burial Date thereof Aug. 31, 1945  
 (Burial, exhumation, or removal, which) (month) (day) (year)

Cemetery or crematory Creagerstown Cemetery

Location Creggerstown, Md.

18. Funeral director Scott F. Minnich &amp; Son

Address Hagerstown, Md.

19. Aug. 29, 1945 Elizabeth G. Hecks  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28 1945 at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19. and that I last saw him alive on Aug 28 1945

Immediate cause of death

Hanging +  
 inhalation of chloroform

DURATION

1 hr. 15 min.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 8-28-45

Where did injury occur? Walkersville, Frederick Co., Md.  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Hanging + chloroform Injured at work? No

23. SIGNATURE P. W. Barr Med Ex

M. D. or other

Address: Frederick, Md. Date signed: 8-28-45

RECEIVED  
SEP 1 1945  
BUREAU V.B.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

08065

Reg. Dist. No. 139

## 1. PLACE OF DEATH:

County FrederickCity or town State Sanatorium, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Since 5/7/45

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis SanatoriumHow long in hospital or institution? Since 5/7/45

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 38 S. Hanover St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Harry Young

## 3. (b) Social Security Number

220-12-8653

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widower

## 6. (b) Name of husband or wife

6. (c) If alive, give age years

## 7. Birth date of

deceased (mo., day, yr.)

April 11, 1904

## 8. AGE:

Years

Months

Days

If less than one day

41329

hrs.

min.

## 9. Birthplace

Quarryville, Pa.

(Town, county, and state)

## 10. Usual occupation

Sheet metal worker

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

Harry Young

## 13. Birthplace

Pennsylvania

## 14. Maiden name

Georgia Ramsey

## 15. Birthplace

Pennsylvania

## 16. Informant

Deceased

## Address

## 17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof 8/13/45

(month) (day) (year)

## Cemetery or place of

Quarryville

## Location

Quarryville, Lancaster Co., Pa.

## 18. Funeral director

S. L. Allison

## Address

Emmitsburg, Md.

## 19.

8/10/45

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 19 45 at 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 7 19 45 to Aug. 9 19 45and that I last saw him alive on August 9 19 45

Immediate cause of death

Pulmonary Tuberculosis

DURATION

5 Mos.~~XXX~~Tuberculous Enteritis1 Mo.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. B. LynnM. D. ~~XXXX~~Address State Sanatorium, Md. Date signed 8/10/45

RECEIVED  
AUG 13 1945  
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 08066  
144

## 1. PLACE OF DEATH:

County ThurmontCity or town Thurmont  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Thurmont  
(If outside city or town limits, write RURAL and give nearest town)Street No. 700  
(If rural, give LOCATION)2.(a) If veteran, name war 700

## 3. (a) FULL NAME

Annie Belle Zentz

## 3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed8.(b) Name of husband or wife David G. Zentz7. Birth date of deceased (mo., day, yr.) January 28, 18666.(c) If alive, give age 78 years

8. AGE:

Years

Months

Days

If less than one day

79610hrs.min.9. Birthplace Frederick Co., Md.  
(Town, county, and state)10. Usual occupation Retired11. Industry or business Housewife12. Name William Zentz13. Birthplace Thurmont, Md.14. Maiden name Elizabeth Stansbury15. Birthplace Thurmont, Md.16. Informant William ZentzAddress Thurmont, Md. P.D.17. Burial Date thereof Aug 10, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory United BrethrenLocation Thurmont, Md.18. Funeral director M. L. GreavesAddress Thurmont, Md.19. Aug 9 1945 Blanche S. Eiler  
(Date reg'd by registrar) Deputy Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 8, 1945, at 3:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 30 1945, to Aug 8 1945, and that I last saw him alive on Aug 7 1945.Immediate cause of death Cerebral HemorrhageDue to Chronic EndocarditisDue to Chronic Arterial Sclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. S. Eiler M.D. M. D. or otherAddress Thurmont, Md. Date signed 8/9/45

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF HEALTH

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON QUALIFIED TO JUDGE OF THE HEALTH OF THE PERSON NAMED HEREIN.

DATE OF EXAMINATION

NOTATION FOR PHYSICIAN'S USE

RECEIVED

AUG 11 1945

BUREAU V.S.